Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964562	A. BUILDING: _____ B. WING _____	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020

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A 000	Initial Comments An unannounced Complaint survey, complaint #2025018201, was conducted at Sheridan Manor on . The facility had deficiencies at the time of the survey.	A 000		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary.	A 032		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 032	Continued From page 1 The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide supervision sufficient to prevent elopement for one (1) of eight (8) residents sampled (Resident #1). The Findings Include: A review of the facility's Policy & Procedure Missing Residents Protocol document by this	A 032		

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A 032	Continued From page 2 surveyor on documented it included the following (copy obtained): 1. Administrator or Administrator on duty (AOD) shall alert ALL staff that a resident is missing. 2. All staff shall participate in conducting a room-to-room search including: a. Utility rooms, storerooms, laundry storage and offices b. Vicinities and surrounding areas; parking lots, gardens, park c. Businesses located around the immediate facility. 3. Administrator on Duty (AOD) shall instruct Security Guard/Receptionist to notify the following persons via phone and or beeper "911" (Leave numerical message followed by *911): a. Administrator b. Owner 4. Administrator on Duty (AOD) shall contact the police, giving as much information as possible: a. Date of birth, gender and race b. Clothing and footwear wearing if known. c. and d. Last time seen by staff. e. Give special attention to any medical conditions, , failure, , conditions, etc., history of or problems with . f. Photograph/picture of resident if available. 5. Administrator or Administrator on Duty (AOD) shall notify the resident's Attending physician of the Resident's disappearance 6. Administrator or Administrator on Duty (AOD) shall notify the resident's family/legal	A 032		

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A 032	Continued From page 3 representative or significant other of the resident's disappearance and instruct them to immediately FACILITY and the POLICE if the resident shows up at their house 7. Administrator or Administrator on Duty (AOD) shall instruct the Care Giver to complete an internal incident report to include as much information as possible: a. Clothing and footwear the resident was last seen wearing. b. Whether or not the resident had money or other personal belongings with him/her. c. Last time the resident was seen by staff. d. Last meal eaten. e. Last time medication was administered. f. Mental status; , alert, oriented, , upset, angry, etc.). A review of the confidential report submitted to the Agency by the facility on 02:48:16 PM documented the following: On . 2025 approximately at 3:45 pm (Staff D) noticed resident (Resident #1) did not return from her day program. (Staff D) Immediately she started to look for the resident. Administrator (Staff A) was notified and started to drive around the facility. At 5pm Law enforcement was notified. Police arrived at the facility at 5:25pm. A police report was filed with the (2 Local Cities), and the administrator contacted the day program; they stated she got on the bus but did not where she got off. Family was notified at around 4pm as well as the MD and case manager. Facility, family members and Police department will continue all efforts until she is found. A review of Resident's 1 Health Assessment (AHCA Form 1823) dated ,	A 032		

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A 032	Continued From page 4 documented her diagnosis included , , Distension, , Hyperlipemia, Fatigue, , , , , . It also documented her status as Poor judgement, Forgetful. And that she was an elopement risk (copy obtained). In an interview with Staff B, Care Giver, on at 10:13 AM she stated the Resident was located the next day and is in the hospital (name of the hospital) presently. She stated she was at work on Friday (off on Saturday -Sunday) and the resident wasn't here when she came to work on Monday. She stated she left around 2:30 Friday and the residents normally come to the facility around 3:00 PM, so she wasn't sure of what happened. In an interview with the Administrator on at 10:51 AM he stated the Resident did not elope from the facility; she never returned from her day program on Thursday . He stated they sent her out to be examined, and she is currently in hospital. He also stated they found her the next day (Friday) in the Publix near the facility. After returning her to the facility on Friday ( ) they sent her out to make sure she was okay, and to have her checked out to make sure she didn't have any issues, bugs, or anything, and they admitted. He stated one of the caregivers found 2:00 and Publix, who went looking for her after she finished her shift at 2:00 PM and found her around 2:30 PM and brought her to the facility. In an interview with the Administrator, Staff A, he stated the procedure is that a staff person watches them get onto the bus in the morning and get off the bus when they return to the facility	A 032		

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A 032	Continued From page 5 in the afternoon. (However, this proedure was not followed through on the day of the elopement). In an interview with Staff C, Caregiver on at 1:13 PM she stated she works 2:00 PM - 9:00 PM and was working the day of the incident. She stated she opened the door for 5 Residents and did not see Resident #1. She stated she didn't know if the Resident had gone with her family, which she does sometimes. She stated the Resident drinks a lot of water at night and doesn't sleep at night but sleeps during the day. Staff C further stated in the interview they use (Chat Program) to track the Residents when they go to the Day Program, and when they return. She proceeded to show this surveyor a string of text message chats documenting such. However, she stated she did not have anything for the day Resident #1 went missing as she wasn't working that morning, and that she came in at 2:00 PM. She stated she spoke with Staff D around 3:00 PM (no definitive time provided) and informed her that Resident #1 was not with the five residents she let into the facility. She stated they started a search, and the Administrator and the Resident's family were called. In an interview with Staff D, MedTech/Caregiver on at 2:11 PM she stated she works 2:00 PM - 9:00 PM and 7:00 AM - 2:00 PM (Friday/Saturday) and is off on Sundays. She stated she came in at 2:00 PM on Thursday , did not see Resident #1 during her rounds and notified staff of the people (Residents) who were at the (Day) Program. She stated that when the Residents came , she was attending to another Resident with care, and she observed the group of people (residents)	A 032		

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A 032	Continued From page 6	A 032		

where but noticed she wasn't here. She stated the Resident normally comes in, sits on the patio and smoke. She stated she spoke with Staff C who stated she counted 5 residents that came in, and Resident #1 was not with them. She stated she told the Administrator that they did not see Michelle come to the facility. She states she contacted the Program and spoke with them and was told that the Resident got on the bus.

Staff D also stated in the interview that she called Resident #1s sister and asked if she had heard from the resident and was told they had not. Staff D further stated the facility's staff checked the video system, but they could not find the footage on the camera as it wasn't working properly. Staff D stated Resident #1's sister stated she informed Resident #1 in a telephone call the previous night that their mother was in (Local Hospital), so Resident # , have been upset at the news. Staff D stated that after being informed by Resident's 1's sister that they hadn't heard from her, she advised the Administrator that they needed to start a search. She stated they called 911 and there was some as to who was supposed to handle the case (Law Enforcement Agency where the Day Program is located, or Law Enforcement Agency where the facility is located) as they were not sure in what city Resident #1 got off the Day Program's bus in.

Staff D further stated in the interview that in her conversation with the Day Program's bus driver on , he stated he dropped the facility's Residents off at the facility. She then stated Resident 1's sister gave names of Resident #1's friends that she may have eloped to and they called them, but they also stated they had not heard from her. She stated they called Resident #1's longtime boyfriend, and he stated he hadn't

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A 032	Continued From page 7	A 032		

heard from her since , (2025). She stated the boyfriend would visit Resident #1 out of the blue, but they never let her leave with him. She stated Resident #1 would leave for a week with the family on occasion. She then stated that she came to the facility at 7:00 AM the next morning and called Resident #1's sister again and was told the Resident had a previous history of going to the homeless place (name provided), so they checked there. She stated the sister also told her that the Resident is pretty resourceful in the streets. She stated she reached out to (Local Police Department) to get an update and they had nothing. She also stated Staff E informed her that she was going to look for her again when she got off at 2:00 PM. Staff E drove around the area and saw Resident #1 at the (Grocery store) near the facility. She stated Resident #1 told Staff E that she was visiting her children. She stated they contacted the (Local Police Department) and informed them that the Resident had been returned, and that they would be sending her to the hospital to be checked. She stated Resident #1 follow directions but is a little at times.

In an interview with Resident #1 on at 2:34 PM she stated she had some scares which started a couple of months ago. She stated she enjoys going to the Day Program and is transported on the van/or bus. She stated she came from the Program on and decided to go for a walk and go visit an old friend she had an , , with. She stated she also took a bus and went to see her friends. She stated she did not inform the facility that she was going but would do so in the future. She stated she wants to go see her kids who live down the street off Sheridan by Griffin, and her ex-husband. She stated she did not come into the

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A 032	Continued From page 8 facility but walked to the bus and started her visits. She stated she went to (Grocery store) the next day ( ) because a lot of her friends were there. In a follow-up interview with Staff D on at 3:38 PM she stated staff were just verbally communicating with each other regarding who went out to the Program and when they came . She stated when they returned, they counted them, did rounds inside the facility to make sure they were here, but did not document anything. On at 1:38 PM a telephone call was made to Day Program/Clinic owner, who stated in the interview they use a sign-in log for attendees, and that Resident #1 attended the Program on Thursday . She stated there were six (6) Residents that came from the facility that day, and that the Residents, including Resident #1, were transported by (private transportation company) that her insurance company uses. She re-stated the Resident left their clinic, boarded the bus and was transported to the facility. In an interview with the Administrator and Staff on at 3:53 PM they were informed/or reminded that Resident's 1's AHCA Form 1823 documented she was an elopement risk, had poor judgement, suffered from and was forgetful. As such, a higher degree of supervision/or observation may be necessary to ensure she was always accounted for. They agreed and stated they would implement additional safeguards immediately. No additional information was provided during the survey.	A 032		

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A 032	Continued From page 9 Class III	A 032		