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
	AL11910896	A. BUILDING _____ B. WING _____	C

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN HOME	34 W 14TH STREET HIALEAH, FL 33010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An Complaint (CCR# 2012007220) Survey was conducted on , 2012 at Christian Home. The following deficiencies were identified at time of survey.	A 000		
A 025 SS=D	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.	A 025		

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A 025	Continued From page 1	A 025		

This Statute or Rule is not met as evidenced by:
Based on record review and interview the facility failed to maintain a written record, updated as needed, of any significant changes for 1 out of 2 (#1) sampled residents.

Findings include:

The facility failed to maintain a written record, updated as needed, of any significant changes for 1 out of 2 (#2) sampled residents. Record review of the facility elopement files contained the Resident Wandering & Elopement Policy and Procedures in facility records and resident files. The last elopement drills were conducted on and . Review of facility incident and accident file contained no documentation of resident #2 leaving facility on and the police being called. Record review of the residents documented staff #2 was admitted to the facility on . The facility failed to assess and have documentation for residents #2 for elopement at admission and after residents #2 eloped multiple times within the last two years from the facility.

Record review on found that residents #2 did not have a photo id with a signed consent form available at the facility. Record review found that the facility did not have photo identification for residents #1 and #2 who had a history of eloping from the facility. Record review on found that residents #2's photo identifications consent form had been signed for the photo. Record review found that the last 1 day incident report that the facility sent to the agency was . Record review of resident #2 notes in file verified he did leave the facility on and was reported missing to police. There was no police

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A 025	Continued From page 2 report to reference and no documentation on record. The facility did not have a separate plan of action will be individually tailored to the resident's needs to avoid future reoccurrences of an incident. Interview at 10:36 a.m. on with staff #2 says " there are only two residents at risk for elopement. They are two Resident #1 & 2. Resident #1 went missing on . He left around 2 p.m. and we went looking for him around the . We called the police around 2:30 p.m. The police found him at Palm Spring Hospital. Resident #2 goes to a program on Wednesday with Pace. We have someone come here to do the activities with the resident ' s every day and resident 1 &2 participates. Resident #2 always says he wants to go home, but he is able to go out if he wants and he likes to go to the corner store sometimes. At 11:03 a.m. on Sunday / Resident #2 left in the afternoon at 5 p.m. and went walking. Staff #5 & 6 as working that day. Staff #5 called the police and he was found on Palm Avenue. Administrator called the son. He is the guardian. I was not here when it happened. I just wrote the notes from what the staff told me. No, I did not complete an incident form.. He has left before and the police has bought him back. " Interview at 11:35 a.m. with staff #5 stated " I was working. On Sunday because he usually sits outside, and when I went to check on him, he was not there. I went to check all the backyard and , and then the streets and around the . Then came back and called the police around 5:30 p.m. and SafetyNet by LOJack. I waited for the police to come, the police question me on a description and then left and was given the number for his lojack. They did not give me a case number.	A 025		

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A 025	Continued From page 3 Then she went home her shift (9 am to 7pm) was over. Staff #4 left at five. Her shift is 8 am-5 p.m. that day. Staff #6 and administrator came in afternoon. The police bought the resident back and the administrator called the son to inform him. I did not document any of it. " Class III	A 025		
A 032 SS=D	58A-5.0182(8) FAC Resident Care - Elopement Standards (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement shall be identified so staff can be alerted to their needs for support and supervision. 1. As part of its resident elopement response policies and procedures, the facility shall 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 attention shall be directed towards residents assessed at high risk for elopement, with special attention given to those with ' and related assessed at high risk. 2. At a minimum, the facility shall have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The photo identification shall be made available for the file within 10 calendar days of admission. In the event a resident is assessed at risk for elopement subsequent to admission, photo identification shall be made available for the file within 10 calendar days after a determination is made that the resident is at risk for elopement. The photo identification may be taken by the facility or provided by the resident	A 032		

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A 032	Continued From page 4 or resident ' s family/caregiver. (b) Facility Resident Elopement Response Policies and Procedures. The facility shall develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures shall include: 1. An immediate staff 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 shall conduct resident elopement drills pursuant to Sections 429.41(1)(a)3. and 429.41(1)(l), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to assess residents at risk for elopement for 1 out of 2 (#2) sampled residents. The facility failed to have a photo identification with a signed consent form for at risk residents for 1 out of 2 (#2) sampled residents. The facility failed to follow their elopement policies and procedures for 1 out of 2 (#2) sampled residents. Findings include: The facility failed to assess and have documentation for residents #2 for elopement at admission and after residents #2 eloped multiple	A 032		

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A 032	Continued From page 5 times within the last two years from the facility. Record review on found that residents #2 did not have a photo id with a signed consent form available at the facility. Record review found that the facility did not have photo identification for residents #1 and #2 who had a history of eloping from the facility. Record review on found that residents #2's photo identifications consent form had been signed for the photo. Record review found that the last 1 day incident report that the facility sent to the agency was . The facility had not completed or filed an incident report for residents #2 who eloped on . The facility did not have a separate plan of action will be individually tailored to the resident's needs to avoid future reoccurrences of an incident. Interview with the administrator on at 10:36 a.m. confirmed that on that residents #2 did not have photo identifications in there records and did not follow the elopement policies and procedures. Class III	A 032		
A 079 SS=D	58A-5.019(4) FAC Staffing Standards - Levels (4) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities shall maintain the following minimum staff hours per week: Number of Residents — Staff Hours/Week 0-5 — 168 6-15 — 212 16-25 — 253 26-35 — 294 36-45 — 335 46-55 — 375	A 079		

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A 079	Continued From page 6	A 079		

56-65 416
66-75 457
76-85 498
86-95 539

For every 20 residents over 95 add 42 staff hours per week.

2. At least one staff member who has access to facility and resident records in case of an emergency shall be within the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.

3. In facilities with 17 or more residents, there shall be at least one staff member awake at all hours of the day and night.

4. At least one staff member who is trained in First Aid and , as provided under Rule 58A-5.0191, F.A.C., shall be within the facility at all times when residents are in the facility.

5. During periods of temporary absence of the administrator or manager when residents are on the premises, a staff member who is at least , must be designated in writing to be in charge of the facility.

6. Staff whose duties are exclusively building maintenance, clerical, or food preparation shall not be counted toward meeting the minimum staffing hours requirement.

7. The administrator or manager ' s time may be counted for the purpose of meeting the required staffing hours provided the administrator is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility ' s staffing schedule.

8. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant

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A 079	Continued From page 7 positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, shall have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents scheduled and unscheduled service needs, resident contracts, and resident care standards as described in Rule 58A-5.0182, F.A.C. (c) The facility must maintain a written work schedule which reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules for direct care staff available to residents or representatives, specific to the resident ' s care. (d) The facility shall be required to provide staff immediately when the Agency determines that the requirements of paragraph (a) are not met. The facility shall also be required to immediately increase staff above the minimum levels established in paragraph (a) if the Agency determines that adequate supervision and care are not being provided to residents, resident care standards described in Rule 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents ' contracts. The Agency shall consult with the facility administrator and residents regarding any determination that additional staff is required. 1. When additional staff is required above the minimum, the agency shall require the submission, within the time specified in the notification, of a corrective action plan indicating how the increased staffing is to be achieved and resident service needs will be met. The plan shall be reviewed by the agency to determine if the plan will increase the staff to needed levels and meet resident needs.	A 079		

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A 079	Continued From page 8 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, modifications may be made in staffing requirements for the facility and the facility shall no longer be required to maintain a plan with the agency. 3. Based on the recommendations of the local fire safety authority, the Agency may require additional staff when the facility fails to meet the fire safety standards described in Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the Agency that fire safety requirements are being met. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of Rule 58A-5.029, 58A-5.030, or 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview the assisted living facility failed to ensure that the facility maintained the minimum staffing hour requirements of 253 hours weekly. Findings include: Record review found that the staffing schedule posted had a total of 239 weekly hours for a census of 19 residents. Record review found that the facility did not have any documentation that it	A 079		

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A 079	Continued From page 9 was maintaining the required 253 weekly hours for a census of 19 residents. Interview with staff #2 on [redacted] at 10:30 a.m. she thought she had scheduled the staff for 253 hours and will revise it to reflect the correct hours. Class III	A 079		
A 165 SS=D	429.23 FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, " adverse incident " means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. [redacted]; 2. [redacted] or spinal damage; 3. Permanent [redacted]; 4. [redacted] or [redacted] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the	A 165		

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A 165	Continued From page 10	A 165		

resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or
7. An event that is reported to law enforcement or its personnel for investigation; or
(b) Resident elopement, if the elopement places the resident at risk of harm or injury.
(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident.
(4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident.
(6) , neglect, or , must be reported to the Department of Children and Family Services as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to

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A 165	Continued From page 11 disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within one (1) business day after the incident on AHCA Form 3180-1024, Assisted Living Facility Initial Adverse Incident Report-1 Day, 2006, and incorporated by reference. The form shall be submitted via electronic mail to riskmgmtps@ahca.myflorida.com; on-line at http://ahca.myflorida.com/reporting/index.shtml; by facsimile to (850)922-2217; or by U.S. Mail to AHCA, Florida Center for Health Information and Policy Analysis, 2727 Mahan Drive, Mail Stop 16, Tallahassee, Florida 32308-5403, telephone (850)412-3731. AHCA Form 3180-1024 is available from the Florida Center for Health Information and Policy Analysis at the address stated above. The Initial Adverse Incident Report is in addition to, and does not replace, other reporting requirements specified in Florida	A 165		

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A 165	Continued From page 12 Statutes. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported under subsection (1) above, the facility shall submit a full report within fifteen (15) days of the incident. The full report shall be submitted on AHCA Form 3180-1025, Assisted Living Facility Full Adverse Incident Report-15 Day, dated 2006, and incorporated by reference. The methods for obtaining and submitting the form are set forth in subsection (1) of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to provide a preliminary report to the agency , within 1 business day after the occurrence of the adverse incident for 1 out of 2 (#2)sampled residents. Findings Include: Record review on of facility and of resident#2's records revealed there was no 1-Day adverse incident report done regarding this resident disappearance on . Record review of the incident report on contained no documentation of a 1 day report file with facility. Record review of resident #2 notes in file verified he did leave the facility on and was reported missing to police. There was no police report to reference and no documentation on record. Interview at 10:36 a.m. on with staff #2 says " there are only two residents at risk for elopement. They are and resident #1 and resident #2. Resident #1 went missing on	A 165		

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CHRISTIAN HOME	34 W 14TH STREET HIALEAH, FL 33010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 165	Continued From page 13 . He left around 2 p.m. and we went looking for him around the . We called the police around 2:30 p.m. The police found him at Palm Spring Hospital. Resident #2 goes to a program on Wednesday with Pace. We have someone come here to do the activities with the resident ' s every day and resident #1 &2 participates. Amos always says he wants to go home, but he is able to go out if he wants and he likes to go to the corner store sometimes. At 11:03 a.m. on Sunday resident #2 left in the afternoon at p.m. and went walking. Staff #5 & 6 was working that day. Staff #5 called the police and he was found on Palm Avenue. Administrator called the son. He is the guardian. I was not here when it happened. I just wrote the notes from what the staff told me. No, I did not complete an incident form.. He has left before and the police has bought him back. " Interview at 11:35 a.m. with staff #5 stated " I was working. On Sunday because he usually sits outside, and when I went to check on him, he was not there. I went to check all the backyard and , and then the streets and around the . Then came back and called the police around 5:30 p.m. and SafetyNet by LOJack. I waited for the police to come, the police question me on a description and then left and was given the number for his lojack. They did not give me a case number. Then she went home her shift (9 am to 7pm) was over. Staff #4 left at five. Her shift is 8 am-5 p.m. that day. Staff #6 and administrator came in afternoon. The police bought the resident back and the administrator called the son to inform him. I did not document any of it. " Class III	A 165		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Christian Home
34 W 14th Street
Hialeah, FL 33010

Re: CCR #2012007220

Dear Administrator:

This letter reports the findings of a state complaint survey that was conducted on , 2012 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe.

Staff from this office will conduct a review after 8/16/2012 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

for Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure
XG90

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