

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HERON'S RUN			STREET ADDRESS, CITY, STATE, ZIP CODE 2939 S. HAVERHILL ROAD WEST PALM BEACH, FL 33415		
(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)	
A 000	Initial Comments		A 000		
	An Assisted Living Facility complaint survey (CCR# 2012011565) was conducted on Heron's Run, had licensure deficiencies found at the time of the visit.				
A 010 SS=D	58A-5.0181(4) FAC Admissions - Continued Residency		A 010		
	(4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (e) of this subsection, criteria for continued residency in any licensed facility shall be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a face-to-face medical examination by a licensed health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule. The form must be completed in accordance with that paragraph. After the effective date of this rule, providers shall have up to 12 months to comply with this requirement. (a) The resident may be bedridden for up to 7 consecutive days. (b) A resident requiring care of a _____ pressure _____ may be retained provided that: 1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a licensed health care provider, or the resident contracts directly with a licensed home health agency or a nurse to provide care; 2. The condition is documented in the resident's record; and 3. If the resident's condition fails to improve within 30 days, as documented by a licensed				

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

9899

J2LN11

If continuation sheet 1 of 10

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HERON'S RUN			STREET ADDRESS, CITY, STATE, ZIP CODE 2939 S. HAVERHILL ROAD WEST PALM BEACH, FL 33415		
(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) COMPLET. DATE
A 010	Continued From page 1 health care provider, the resident shall be discharged from the facility. (c) A _____ ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to the services of a licensed hospice which coordinates and ensures the provision of any additional care and services that may be needed; 2. Continued residency is agreeable to the resident and the facility; 3. An interdisciplinary care plan is developed and implemented by a licensed hospice in consultation with the facility. Facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living; and 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility. (e) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. (5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or licensed health care provider, the resident shall be discharged in accordance with Section 429.28(1), F.S.	A 010			
This Statute or Rule is not met as evidenced by:					

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HERON'S RUN			STREET ADDRESS, CITY, STATE, ZIP CODE 2939 S. HAVERHILL ROAD WEST PALM BEACH, FL 33415		
(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 010	Continued From page 2 Based on record review and interview, it was determined the facility failed to ensure a Health Assessment form was completed on every resident upon significant change and that it is reflective of the resident's current health status and care needs, for 1 out of 3 sampled residents (Resident #1). The findings include: During an interview with the Administrator (by phone) and the facility's Nurse at 9:15 AM on _____, it was revealed Resident #1 eloped from the facility on _____ and was not located until _____. It was also revealed the resident had not exhibited any elopement tendencies prior to the elopement date of _____. Record review of Resident #1's file indicated an admission date of _____. Health Assessment dated _____ documented a medical diagnosis as _____, s/p fx left hip, _____, high _____, _____, osteopenia, _____, _____, hallucinations, _____, _____, _____, aneurysm, and skin _____. Physical or sensory limitations per health assessment documented as unable to ambulate independently requires staff assistance use walker. _____ or behavioral status per health assessment documented as forgetful at times to place and time, _____ and history of hallucinations. Activities of Daily Living (ADLs) requirements documented as needs assistance. Resident noted to be appropriate for placement in an Assisted Living Facility as documented on health assessment. Further review of the health assessment indicated the resident required daily oversight with observing well-being, observing whereabouts and reminders for important tasks, in which comments documented as staff monitor safety. Further record review failed to indicate a current health	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL11963962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HERON'S RUN			STREET ADDRESS, CITY, STATE, ZIP CODE 2939 S. HAVERHILL ROAD WEST PALM BEACH, FL 33415		
(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)	
A 010	Continued From page 3		A 010		
	assessment since the significant health change of the resident (the elopement). Further interview with the Administrator and the DON at 11:15 AM, it was revealed the facility did not have a current health assessment reflecting the current health changes and current ADLs level for the resident, including appropriateness for an Assisted Living Facility since the documented elopement of the resident on . . . Class III				
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		A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HERON'S RUN			STREET ADDRESS, CITY, STATE, ZIP CODE 2939 S. HAVERHILL ROAD WEST PALM BEACH, FL 33415		
(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)	
A 025	Continued From page 4		A 025		
	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. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined to the facility failed to ensure adequate supervision is provided to all residents based on needs, for 1 out of 3 sampled residents (Resident #1). The findings include: Record review of Resident #1's file and facility's incident reports, including adverse incident reports (1 day & 15 day), documented that Resident #1 eloped from the facility on _____ and was returned on _____ by law enforcement. Record review revealed Resident #1 was not provided with adequate supervision with respect to his medical diagnosis and care needs (as noted on the resident's health assessment). Review of Resident #1's health assessment dated _____ documented medical diagnoses as _____, s/p fx left hip, _____, high _____, osteopenia, _____, hallucinations, _____, _____, aneurysm, and skin _____. Physical or sensory limitations per health assessment documented as unable to ambulate independently requires staff assistance uses walker. _____ or behavioral status per health assessment documented as forgetful at times to place and time, _____ and history of hallucinations. Activities of Daily Living (ADLs) requirements documented as needs				

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HERON'S RUN			STREET ADDRESS, CITY, STATE, ZIP CODE 2939 S. HAVERHILL ROAD WEST PALM BEACH, FL 33415		
(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)	
A 025	Continued From page 5		A 025		
	assistance. Resident noted to be appropriate for placement in an Assisted Living Facility as documented on health assessment. Further review of the health assessment indicated the resident required daily oversight with observing well-being, observing whereabouts and reminders for important tasks, in which comments documented as staff monitor safety. On _____ it was noted the facility failed to provide adequate supervision to Resident #1 resulting in Resident #1 eloping from the facility. The facility's failure to provide adequate supervision to Resident #1 jeopardized the resident's safety and well-being. Class III				
A 160	58A-5.024(1) FAC Records - Facility SS=D		A 160		
	Records. The facility shall maintain the following written records in a form, place and system ordinarily employed in good business practice and accessible to Department of Elder Affairs and Agency staff. (1) FACILITY RECORDS. Facility records shall include: (a) The facility's license which shall be displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the place from which the resident was admitted, and if applicable, a notation the resident was admitted with a pressure _____; and 2. Date of discharge, the reason for discharge, and the identification of the facility to which the resident is discharged or home address, or if the person is _____, the date of _____.				

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HERON'S RUN			STREET ADDRESS, CITY, STATE, ZIP CODE 2939 S. HAVERHILL ROAD WEST PALM BEACH, FL 33415		
(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)	
A 160	Continued From page 6		A 160		
	Readmission of a resident to the facility after discharge requires a new entry. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intends to return pursuant to Rule 58A-5.025, F.A.C. (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) An up-to-date record of major incidents occurring within the last 2 years. Such record shall contain a clear description of each incident; the time, place, names of individuals involved; witnesses; nature of injuries; cause if known; action taken; a description of medical or other services provided; by whom such services were provided; and any steps taken to prevent recurrence. These reports shall be made by the individuals having first hand knowledge of the incidents, including paid staff, volunteer staff, emergency and temporary staff, and student interns. (e) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described under Rule 58A-5.026, F.A.C., which shall be located where immediate access by facility staff is assured. (f) Documentation of radon testing conducted pursuant to Rule 58A-5.023, F.A.C.; (g) The facility's liability insurance policy required under Rule 58A-5.021, F.A.C.; (h) For facilities which have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C. (i) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 58A-5.0182, F.A.C. (j) If the facility advertises that it provides special				

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HERON'S RUN			STREET ADDRESS, CITY, STATE, ZIP CODE 2939 S. HAVERHILL ROAD WEST PALM BEACH, FL 33415		
(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)	
A 160	Continued From page 7		A 160		
	care for persons with _____ or related _____, a copy of all such facility advertisements as required by Section 429.177, F.S. (k) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C. (l) All food service records required under Rule 58A-5.020, F.A.C., including menus planned and served; county health department inspection reports; and for facilities which contract for catered food services, a copy of the contract for catered services and the caterer's license or certificate to operate. (m) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last two (2) years. (n) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (o) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (p) Additional facility records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. (q) The facility's resident elopement response policies and procedures. (r) The facility's documented resident elopement response drills.				

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED _____
NAME OF PROVIDER OR SUPPLIER HERON'S RUN			STREET ADDRESS, CITY, STATE, ZIP CODE 2939 S. HAVERHILL ROAD WEST PALM BEACH, FL 33415		
(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 160	Continued From page 8	A 160			
	This Statute or Rule is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to ensure detailed and complete records (incident reports) are maintained for all major incidents or significant changes involving a resident, for 1 out 3 sampled residents (Resident #3). The findings include: Resident #3 was admitted to the facility on Review of Resident #3's health assessment dated, documented a medical diagnosis of " See attached ". There were no additional documents attached to the health assessment indicating the resident's diagnosis. Physical or sensory limitations per health assessment documented as resident ambulates with the aid of a wheelchair. or behavioral status concerns documented as resident has a diagnosis of, Activities of Daily Living (ADLs) requirements documented as needs assistance. Resident noted to be appropriate as documented on health assessment. Review of observation notes and incident report dated, documented the resident .. asleep in chair and tipped over and out of the chair. Both forms of documentation documented notification to appropriate persons but failed to document witnesses involved and further steps taken to prevent reoccurrences. During an interview with the Nurse at 10:30 AM on she revealed no further documentation was available for review regarding Resident#3's incident that occurred on				

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HERON'S RUN			STREET ADDRESS, CITY, STATE, ZIP CODE 2939 S. HAVERHILL ROAD WEST PALM BEACH, FL 33415		
(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 160	Continued From page 9 Class III	A 160			



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Heron's Run
2939 S. Haverhill Road
West Palm Beach, FL 33415

Re: CCR #2012011565

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2012 by a representative from 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 , 2013 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 representative. Should you have any questions please call this office at (561) 381 - 5840.

Sincerely,

Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure

XG90

