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
	AL11966232	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & R PERSONAL CARE INC	1289 HILLSBOROUGH AVE ARCADIA, FL 34266

(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 unannounced Complaint Survey, CCR 2013002826 was conducted on through at M & R Personal Care an Assisted Living Facility (ALF) in Arcadia, Florida. There were 2 allegations which were both substantiated and state deficiencies were identified as a result of this survey.	A 000		
A 032	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 s 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	A 032		

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be taken by the facility or provided by the resident 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)(i), F.S.

This Statute or Rule is not met as evidenced by:
Based on record review, interview and observation, the facility failed to assess residents as being at risk for elopement and failed to identify 2 (Residents #1 and #3) of 3 residents reviewed as being at risk for elopement. The facility failed to ensure 3 (Residents #1 ,#2, and #3) residents of having a history of elopement had photographs known and accessible to all staff. The facility failed to monitor 1 (Resident #1) mentally challenged resident, closely and allowed him to leave the facility without supervision resulting in the resident not being found. The facility failed to conduct elopement drills with all

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staff and instruct all staff on facility policies regarding elopement.

The findings include:

A tour was not conducted until 10:30 a.m., because facility was not able to quickly supply the surveyor with a list of current residents. Staff was asked for a current resident list on entry to the facility. They were asked at 9:00 a.m. and after 20 minutes Staff A brought a resident list, and then took it back to make correction.

At 10:00 a.m., Staff A was asked again for a resident list. The Administrator stated to Staff A, "Get him a face to face sheet. That will have all the residents on it." The surveyor was then given a paper titled, "Face Check Sheet M&R Personal Care." The first resident the surveyor made face to face contact with stated he was Resident #6. In checking the list given by the facility the resident was not found listed.

An interview was conducted with Staff A at 10:32 a.m. on . She stated, "I forgot to put him on there." She then was observed to write the name of Resident #5 and Resident #6 on the form. She was asked who Resident #5 was and she stated, "He's in the hospital."

A face to face was then done with all residents. All were found to have observable mental health issues.

An interview was conducted with Staff D, . . . (Resident Assistant), at 10:20 a.m. on . She was asked which residents at the facility were elopement risks. She stated, "Resident #2 is the only one I know of." Resident #3 was observed within a few minutes time. He was

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observed to be nonverbal. At that time Staff D was asked about Resident #3. She stated, "We have to watch him too. He's been known to run off."

The Administrator handed the surveyor a resident list which she had hand written at 10:35 a.m. on . The list had all 13 residents in the building including Residents #5 and #1. Beside Resident #1's name the Administrator had written "Elopement Precautions." No other resident was designated on the list to have elopement precautions.

At 9:30 a.m. on , an interview was conducted with Staff A. She stated she was working on and witnessed Resident #1 walking out the gate of the facility. She stated he had not signed out and she shouted at him to come back. She stated she went back into the facility to get her car keys and on return the resident was not in sight anymore. She stated she called the police at 6:58 p.m. on . She stated the police searched the area and could not locate the resident. She stated she drove around the area and could not locate the resident. Deputies came back the next morning to file a missing persons report. She stated, "He has not been right since they took him off a couple of years ago. He says he's superman and batman all the time."

An interview was conducted with Staff B at 9:53 a.m. on . He stated he saw, through the kitchen window while he was washing dishes, Resident #1 running out. Staff B stated he went to the rodeo grounds and looked for the resident. He stated there were a lot of young people there but Resident #1 was nowhere in sight. He stated he has looked for the resident every day since he

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left the facility. He stated he checked the KOA campground where the resident was picked up by the police about 2 years before eloping on . . . . He stated, "I would not consider him (Resident #1) an elopement risk. It was over two years ago when the police found him near the KOA campground."

The facility's yard was observed at 9:50 a.m. on . . . . . The distance from the front door of the facility to the wooden gate going out of the facility was between 25 to 30 yards. The wooden gate leading onto the street was observed to be large enough for one vehicle to drive through.

Review of a report obtained by The Desoto County Sheriff's Office CFS report shows deputies were called for a missing person on . . . . at 10:20 a.m. to the facility. The missing person was Resident #3. According to the report the resident was found across the street and returned to the facility.

On . . . . at 11:20 a.m., Resident #3 was observed to be non-interviewable. When asked questions by the surveyor he was nonresponsive. He was observed to have . . . . He was observed sitting in the living . . . . . with several other residents removing his pants. Staff B was observed assisting him in putting them back on.

Resident #2 was observed at 10:10 a.m. on . . . . to be . . . . slow. She was asked if she had ever left the facility without permission. She stated, "That was a long time ago." She was unable to recall the circumstances to the elopement.

Review of the Facility Policy shows, "Any staff

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who sees a Resident, requiring supervision, walking out and away from the Facility should notify other staff immediately and follow the Resident. Do not leave the Resident alone. Staff should then try to redirect Resident back to the Facility."

At 1:20 p.m. on . Staff A was asked who she thought was at risk for elopement in the facility. She stated Resident #3 had eloped from the facility before. She stated his family had informed the facility he was an elopement risk. She stated, the whole town of Arcadia knows Resident #2 is at risk to elope.

An interview was conducted with Staff D at 1:40 p.m. on . She was asked if she knew which residents were elopement risks. She stated Resident #2 would elope. She stated Resident #2 had never left while she was working. She was asked if any residents had a picture that could be used for identification in their charts. She stated she didn't know of any of the residents having pictures. She was asked if she knew the policy of the facility regarding elopement. She stated she had worked at the facility for a year. She remembered participating in two elopement drills. She was not able to recall the Facilities Policy on elopement.

Review of the elopement drills for the last 2 years show Staff D had not been included in the drills. The Administrator never participated in the elopement drills. There was no documentation staff reviewed the Facility's Policy regarding elopement during the drills.

An interview was conducted with Staff B at 1:45 p.m. on . He was not able to identify if Resident #1 was an elopement risk. He stated he

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was not aware of any of the residents having picture in their charts for identification. He was asked if any residents had identification on their person. He stated he was not aware of any resident having identification.

An interview was conducted with Staff A and the Administrator at 1:55 p.m. on . They were asked about the policy of elopement in the facility. Staff A stated she didn't know it was in the policy she needed to follow the resident and not take her eyes off him. The Administrator stated, "I told you, you should have followed him and not left him alone. Our Policy says you should have never taken your eyes off him." Staff A stated, "I'm too old to be running down the street after people." Staff A then verified 2 staff members observed the resident leaving the facility and neither staff member went with the resident or attempted to keep him in their sight as stated by Facility Policy. Staff A verified she was not aware this was a Policy of the Facility.

At 2:00 p.m. on 3/1 Administrator was asked how she would identify a resident was an elopement risk. She stated, "We know Resident #2 is a risk. Basically that's the only one except for Resident #1. He walked off before. He wasn't really considered a risk cause when he goes somewhere he would come back most of the time." She then stated, "If a person walks off they would be a risk." She then stated Resident #3 had eloped from the facility. She stated, "Anyone who walks off without permission is an elopement risk."

During an interview with Staff C on 3/1 3:00 p.m., she stated she had worked for the facility for 4 to 5 years. She stated the only

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resident she knew was an elopement risk was Resident #2. She stated she was not aware if the residents had identification. She stated she did not know of any resident having pictures in the chart or identification on their person. She stated she had never been involved in an elopement drill and she had not read the Facility's Policy regarding elopement. She stated she knew Residents #1 and #2 were elopement risks.

Review of Resident #1's record shows he had identification that had expired on .

During an interview with Staff A, on at 2:10 p.m., she stated Resident #1 no longer looks like he did when the picture was taken on the identification because he had gained a lot of weight.

Review of Resident #2's medical record showed no picture identification in her chart. She was the only resident identified by all staff as being an elopement risk.

Review of Resident #3's record shows his picture identification had expired on .

An interview was conducted with the Desoto Sheriff's dispatcher at 5:30 p.m. on . She stated, "We know him (Resident #1) well. He usually is only gone for an hour or two and then he goes back home."

Review of a report obtained by The Desoto County Sheriff's Office shows deputies were called for a missing person on at 10:20 a.m. to the facility. The missing person was Resident #3. According to the report the resident was found across the street and returned to the facility.

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On [redacted] at 11:20 a.m., Resident #3 was observed to be non-interview able. When asked questions by the surveyor he was nonresponsive. He was observed to have [redacted]. He was observed sitting in the living [redacted] with several other residents removing his pants. Staff B was observed assisting him in putting them back on. Review of the resident's Observation Record shows no documentation of the resident eloping on [redacted].

Review of Desoto County Sheriff's Office CFS report shows Deputies were called to the Facility on [redacted] at 4:06 a.m. for a missing person. The report shows Resident #2 was found and returned to the facility.

During an interview with the Administrator on [redacted], at 5:00 p.m., she verified both residents had eloped on those dates. She stated she had been the one to call the police when Resident #3 had gone missing. She stated she was very concerned when he went missing. She stated Resident #3 was found across the street from the facility. She stated no Adverse Incident report had been filed for the elopement on [redacted] or for the elopement which occurred on [redacted]. She stated all residents at one time had picture IDs. She stated she believed they had been lost over time.

Review of adverse incidents filed by the facility over the last 2 years and the Desoto County Sheriff's report shows 5 residents eloped from the facility within the last 2 years. Three of those Residents eloped within the last 6 months.

Class II

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A 165	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. ; 2. or spinal damage; 3. Permanent ; 4. or 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 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	A 165		

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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 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.

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(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 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

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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 file an adverse incident on 2 separate occasions when 2 (Residents #2 and #3) residents eloped from the facility. The facility failed to file an adverse incident report in a timely manner when 1 (Resident #1) resident eloped from the Facility.

The findings include:

Entrance to the facility was at 8:30 a.m. on . . . . . Contact was made with Staff B in charge at the time. I gave her my card and informed her that I was here for a complaint. I informed her that I was here for failure to file a report. At this statement Staff B became very agitated and raised her voice and stated, "You're here for (Resident #1) running off. I filed that report." The surveyor neither confirmed nor denied what resident was named in the complaint. The surveyor then told Staff B the complaint also had an allegation of for failure to provide supervision. A request was made in entry for a resident census and a list of current direct care staff. Staff B stated several times "I filed that report." She was then observed to call the Administrator. She was heard telling the Administrator, "ACHA is here and they're saying I never filed a report I know I filed that report."

At 9:10 a.m., the Administrator arrived at the facility. She stated, "We filed that report." She then handed the surveyor a report that had been

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
	AL11966232	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & R PERSONAL CARE INC	**1289 HILLSBOROUGH AVE ARCADIA, FL 34266**

(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	A 165		

filed by the facility. The report showed a date of [redacted] as the day the report was filed. It was at that time the surveyor pointed out to the Administrator the incident occurred on [redacted]. The Administrator was observed on the phone with an individual. She was heard discussing with this person why the report was not filed until [redacted]. After hanging up the phone the Administrator stated, "I have a girl that does not work for me. She helps me with computer work. The report was taken to her the day the incident occurred. This girl forgot to file the form to the website." She was then overheard telling Staff A, "Don't send anything else to her." The Administrator then verified the report was not filed in a timely manner.

Review of a report obtained by The Desoto County Sheriff's Office CFS report shows deputies were called for a missing person on [redacted] at 10:20 a.m. to the Facility. The missing person was Resident #3. According to the report the resident was found across the street and returned to the facility.

On [redacted] at 11:20 a.m., Resident #3 was observed to be non-interview able. When asked questions by the surveyor he was nonresponsive. He was observed to have [redacted]. He was observed sitting in the living [redacted] with several other residents removing his pants. Staff B was observed assisting him in putting them back on.

Review of the resident's Observation Record shows no documentation of the resident eloping on [redacted].

Review of Desoto County Sheriff's Office CFS report shows Deputies were called to the Facility

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
	AL11966232	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M & R PERSONAL CARE INC	1289 HILLSBOROUGH AVE ARCADIA, FL 34266

(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 14 on ... at 4:06 a.m., for a missing person. The report shows Resident #2 was found and returned to the facility. Resident #2 was observed at 10:10 a.m. on to be slow. She was asked if she had ever left the facility without permission. She stated, "That was a long time ago." She was unable to recall the circumstances to the elopement. During an interview with the Administrator on at 5:00 p.m., she verified both residents had eloped on those dates. She stated she had been the one to call the police when Resident #3 had gone missing. She stated she was very concerned when he went missing. She stated Resident #3 was found across the street from the facility. She stated no Adverse Incident report had been filed for the elopement on or for the elopement which occurred on ... Class III	A 165		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
M & R Personal Care Inc
1289 Hillsborough Ave
Arcadia, FL 34266

Re: CCR #2013002826

Dear Administrator:

This letter reports the findings of a Complaint survey that was conducted on , 2013 by a representative 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 , 2013 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

You are directed to provide a plan of correction to the Fort Myers Field Office for the identified deficiencies within ten calendar days of receipt of this faxed report. The plan should be directed to the attention of Mr. Harold Williams, Field Office Manager and mailed to:

Agency for Health Care Administration
Health Quality Assurance, Fort Myers Field Office
2295 Victoria Avenue, Suite 340
Fort Myers, FL 323901
Phone: (239) 335-1315
Fax: (239) 338-2372

The survey resulted in findings of noncompliance with the following areas:

1) A 032 - Resident Care-Elopement Standards - Class II

Your Assisted Living Facility failed to assess residents as being at risk for elopement and failed to identify 2 residents as being at risk for elopement. The facility failed to ensure 3 residents who have a history of elopement were known to all staff and had photographs accessible to all staff. The facility failed to monitor 1 resident closely and allowed him to leave the facility without supervision resulting in the resident not being

found. The facility failed to conduct elopement drills with all staff and failed to instruct all staff on facility policies regarding elopement.

2) A 165 – Risk Management & QA; Adverse Incident Report – Class III

Your Assisted Living Facility failed to file an adverse incident on 3 separate occasions when residents eloped from the facility and local law enforcement was called and came to the facility.

Your plan of correction must include the following:

1) Immediately assess all residents for elopement risk.

2) Update all resident records to include current pictures of residents who are an elopement risk.

3) Make all updated resident records accessible to all staff on each shift.

4) Train all staff on elopement procedures and conduct elopement drills. Make sure that all staff participate in these elopement drills. Document and maintain documentation in files.

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. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosure: State Form