

Agency for Health Care Administration

|                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                |                                                                                                                          |                          |                               |
|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11953342</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PROFESSIONAL HOME CARE III, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>447 EAST 26 STREET<br/>HIALEAH, FL 33013</b>                                 |                          |                               |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                               |
| A 000                                                                      | Initial Comments<br><br>A Complaint Investigation Survey CCR<br>2013002686 was conducted on _____, 2013.<br>Professional Home Care III Inc had deficiencies<br>found at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A 000                                                                          |                                                                                                                          |                          |                               |
| A 032<br>SS=D                                                              | 58A-5.0182(8) FAC Resident Care - Elopement<br>Standards<br><br>(8) ELOPEMENT STANDARDS.<br>(a) Residents Assessed at Risk for Elopement.<br>All residents assessed at risk for elopement or<br>with any history of elopement shall be identified<br>so staff can be alerted to their needs for support<br>and supervision.<br>1. As part of its resident elopement response<br>policies and procedures, the facility shall make, at<br>a minimum, a daily effort to determine that at risk<br>residents have identification on their persons that<br>includes their name and the facility's name,<br>address, and telephone number. Staff attention<br>shall be directed towards residents assessed at<br>high risk for elopement, with special attention<br>given to those with _____ and<br>related _____ assessed at high risk.<br>2. At a minimum, the facility shall have a photo<br>identification of at risk residents on file that is<br>accessible to all facility staff and law enforcement<br>as necessary. The photo identification shall be<br>made available for the file within 10 calendar<br>days of admission. In the event a resident is<br>assessed at risk for elopement subsequent to<br>admission, photo identification shall be made<br>available for the file within 10 calendar days after<br>a determination is made that the resident is at<br>risk for elopement. The photo identification may<br>be taken by the facility or provided by the resident<br>or resident's family/caregiver.<br>(b) Facility Resident Elopement Response<br>Policies and Procedures. The facility shall | A 032                                                                          |                                                                                                                          |                          |                               |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0000

11DN11

If continuation sheet 1 of 3

Agency for Health Care Administration

|                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                |                                                                                                                          |  |                               |
|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11953342</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PROFESSIONAL HOME CARE III, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>447 EAST 26 STREET<br/>HIALEAH, FL 33013</b>                                 |  |                               |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE      |
| A 032                                                                      | <p>Continued From page 1</p> <p>develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures shall include:</p> <ol style="list-style-type: none"> <li>1. An immediate staff search of the facility and premises;</li> <li>2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities;</li> <li>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</li> <li>4. The continued care of all residents within the facility in the event of an elopement.</li> </ol> <p>(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.</p> <p>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 of 2 (#1) sampled residents. The facility failed to follow their elopement policies and procedures for 1 of 2 (#1) sampled residents.</p> <p>Findings include:</p> <p>The facility failed to report elopement to the agency.</p> <p>Facility contains elopement policies on file and elopement drills which have completed. Record review on _____ at 9:25 a.m. found that resident #1 did have a photo ID with a signed consent form available at the facility. Record review found that the 1 day incident report was</p> | A 032                                                                          |                                                                                                                          |  |                               |

Agency for Health Care Administration

|                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                          |  |                               |
|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11953342</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PROFESSIONAL HOME CARE III, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>447 EAST 26 STREET<br/>HIALEAH, FL 33013</b>                             |  |                               |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE      |
| A 032                                                                      | <p>Continued From page 2</p> <p>not sent to the agency. The facility had not completed or filed an incident report for resident #1 who eloped in . The facility did not have a separate plan of action individually tailored to the resident's needs to avoid future reoccurrences of an incident. There were progress notes documenting this incident.</p> <p>Interview with the administrator on 1:10 p.m. confirmed that a report was not filed with the agency she stated;" I didn 't think I had to report it since he we knew he has at the hospital the next day, I will review our elopement policy with the staff and residents, also have a meeting with all our residents and review our open door policy and remind them to be mindful of making sure the gate is locked before they leave or come back into the facility. "</p> <p>Class III</p> | A 032                                                                          |                                                                                                                          |  |                               |



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

, 2013

Administrator  
Professional Home Care III, Inc  
447 East 26 Street  
Hialeah, FL 33013

Dear Administrator:

Re: CCR #2013002686

This letter reports the findings of a state complaint survey that was conducted on , 2013 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 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

