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
	AL11953250	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD RETIREMENT	1117 MASSACHUSETTS AVENUE SAINT CLOUD, FL 34769

(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 . . . . . Complaint inspection CCR 2013004214 was conducted. The facility had deficiencies found during the visit.	A 000		
A 025	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 This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure it provided personal supervision as appropriate to 2 of 3 sampled Limited Mental Health (LMH) residents (#1 and #2) accepted for admission to the facility, which were unable to use good judgment and make appropriate decisions. Findings: Observations upon arriving at approximately 11AM to the facility noted the front main, door was wide open. The office was to the left on the entrance and you could not see who came in and who went out. There was no chime or bell to alert the staff when someone entered or left the facility. 1. Review of the St Cloud Police Department reports on said date at approximately 11AM revealed: St Cloud Police Department interrogation card indicated that resident #1 was loitering "trespassing" outside a business on [redacted] at 1033 hours. St Cloud Police Department electronic incident report form dated [redacted] at 20:16 indicated that on Sunday [redacted] at 21:28 resident #1 was reported missing by a facility staff. In her statement she stated when she reported to work on [redacted] at 1500 she did not see resident #1 in the screened porch but thought nothing of it as the resident sometimes walked around the [redacted]. At 2128 (9:28 PM) the resident had not returned, so she called the police. The staff did not know what the resident had on. She said the resident had been living there for a few months, was free to go and come but always returned. On [redacted] the owner told the investigator that he had not heard from the resident. The FACT team (Mental Health Provider) provided some telephone numbers of relatives, including her mother. The	A 025		

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A 025	Continued From page 2	A 025		

resident's mother stated she had not seen the resident in 12 years and would not recognize her if she saw her, but she would love to go to Miami. On [redacted] the investigator became aware that the resident was in the area on [redacted]. On [redacted] a friend to the resident called the investigator; he had spoken to her. She was upset because she was trespassed at a local business and was leaving towards Miami. On [redacted] at approximately 0939 a police officer made contact with the resident in front of Wawa located at 2184 East Irlo Bronson Highway Kissimmee (intersection of Simpson Road). He asked her if she wanted to return to the facility. She said she had to gather something. She led the officer to a wooded area south west of the Family Dollar located at 2180 East Irlo Bronson Memorial Highway, Kissimmee. She was at a homeless camp that had 4 or 5 tents. She stated she thought the facility was upset with her. She did not express any foul play and ran away voluntarily. She was very hungry and thirsty. He returned her to Homestead.

Another St Cloud Police Department missing person report dated [redacted] indicated that on Monday [redacted] 23:53 resident #1was reported missing by the facility administrator/owner. The report indicated that resident #1 was last seen on [redacted] at 2200 sleeping hours in her [redacted] by a facility staff. On [redacted] at 2300 the administrator was told the resident had not returned. At about 2345 she called the police. She told the officer that the resident had run away before was a [redacted] and took medications. The police office checked the homeless camp to no avail. In the statement given to the police the administrator stated the staff told her at approximately 1:30 PM on Sunday [redacted] that she had not seen resident #1 since Saturday at breakfast. Thought she was out

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A 025	Continued From page 3 panhandling. The night staff told the administrator that he had seen resident#1 in her bed about 11PM. The facility's elopement policy indicated "Elopement is by definition anytime a resident leaves the property of the facility without prior authorization and or direct supervision of staff/ family House rules: Requested to notify staff when they leave the building and also their whereabouts". Resident #1 had a health assessment report dated ____ listed- ____ & ____. She had diagnosis of ____, and Wilson's ____ ____ Was independent with ADLs; The dietary needs and whether or not assistance was needed with medication was blank. The initial wandering assessment ____ indicated, been in ALF yes, med that cause ____ yes. The day 1 adverse report dated Saturday, ____, 2013 at 9:45 PM and received by the Agency on Monday ____ indicated the resident was not in the facility since lunch on ____ Facility note dated ____ resident left facility for 3 days because police talked to her regarding ____ ____, 7-3 (name) is out - 3-11 (name) still out, 11-7 still out 4/8 7-3 (name) still out, 3-11 still out 4/9 7-3 still missing ____ still missing, God bless her ____ 3-11 still missing ____ (name) still missing Continued record review revealed among her multiple medications also included ____ 100mg twice daily ____ 100 daily ____ treatment), ____ at bedtime (for ____ mg three times daily (for ____ and Dilvalporex ER Sod 500 mg twice daily (for ____ medication).	A 025		

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A 025	Continued From page 4 2. Resident #2 had a health assessment dated [illegible] that indicated [illegible] diagnosis of [illegible] 2, osteopenia, history of [illegible] independent wit ADL and, assistance was needed with medications. Initial wandering/ elopement assessment. Resident has history of walking away from facilities without notice. If questions 4, 5 6 or 7 are yes, resident at risk. Had eloped in the past- yes, was in ALF before-yes Notes [illegible] to [illegible] (name) out with family 3/6 back [illegible] 7-3 (name) has been out since sometime last night [illegible] 3-11 (name) still out, the administrator (name) was aware of (name) resident not back. She was here and called 911. Police came. The information was given by staff (names). [illegible] 11-7 Still out, [illegible] 3-11 still out, all shifts [illegible] 11-7 resident (name) is back [illegible] 3-11 (name) is out (walked off) 11PM (name) is home was seating at a bench at Wal-Mart, waiting for aunt to bring her money. Her medications included [illegible] 2 mg, half tablet in the morning and one tablet at night, Divalporex Sod 600 mg 2 in the morning and one at night. The administrator stated at the time that she wanted to discharge the residents because they needed more supervision that she cannot provide but she had not given the residents or their case managers 45 day notice to move out. She added that no interventions were in place to prevent the elopements from continuing. The assistant administrator stated there was nothing that could be done to secure the doors because the St Cloud Fire Marshall would not allow the door to be locked and they tried a bell and did not work.	A 025		

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A 025	Continued From page 5 Class II	A 025		
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 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 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:	A 032		

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A 032	Continued From page 6 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 observations, record review and interview the facility failed to ensure 1 resident in a sampled of 3 who was identified at risk of elopement had identification on her person that included their name and the facility's name, address, and telephone number for 1 of 3 sampled residents (#2). Findings During the entrance at approximately 10 AM, the administrator stated resident #2 was an elopement risk, as she had eloped from the facility before. Observations of the resident at approximately 11:30 AM noted, she was in bed sleeping. The administrator woke her up to ask if she had identification. She replied no. The resident approached the surveyor at approximately 11:30 AM and told her that she had an identification that the hospital had given her; it had her picture and full name. Class III	A 032		

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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 incident, by electronic mail, facsimile, or United	A 165		

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A 165	Continued From page 8 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. (9) The adverse incident reports and preliminary	A 165		

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A 165	Continued From page 9	A 165		

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 obtaining and submitting the form are set forth in

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A 165	Continued From page 10 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 ensure that adverse reports were submitted to the Agency within the mandated time frames for 1 03 smpled residents (#2). Findings: Review of the facility's adverse reports at approximately 11:30 AM revealed the following: A 15 day adverse report dated [redacted] indicated resident #1 eloped on Saturday [redacted] She had not been seen since lunchtime on [redacted] The 15 day adverse report should have been submitted to the Agency 15 calendar days after the occurrence of the incident (due [redacted] A 1-day adverse report dated [redacted] indicated resident #1 eloped from the facility on Sunday [redacted] exact time unknown. The 1 day report needed to be submitted within 1 business day of the occurrence, Monday [redacted] The owner/administrator stated at the time that the former administrator quit unexpectedly and she had taken over and was learning and becoming familiar with the office, as the former administrator had autonomy over the office. She added that she was [redacted] with the adverse reporting because sometimes it indicated withdrawn. 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
Homestead Retirement
1117 Massachusetts Avenue
Saint Cloud, FL 34769

Dear Administrator:

Re: CCR #2013004214

This letter reports the findings of a state licensure 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 **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 surveyor(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
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