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
	AL11953412	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAPPINESS CARE CENTER II, INC	**1105 W 2ND AVENUE HIALEAH, FL 33010**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A Complaint Investigation survey CCR#2013005805 was conducted on at Happiness Care Center II Assisted Living Facility had deficiencies found at the time of the visit.	A 000		
A 025 SS=J	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.	A 025		

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A 025	Continued From page 1	A 025		

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to provide appropriate supervision of mental health residents who have eloped from the facility and have been physically harmed by other residents. The facility failed to document the location of residents and the general awareness, safety, and emotional wellbeing of residents within or away from the facility. This affected 3 out of 10 sampled residents.

The findings included:

1. Record review revealed resident # 9 has left the facility on several occasions without returning for days at a time. A police report, about the missing resident, was completed on , 2013 by the local police department, but the Agency for Health Care Administration (AHCA) was never notified via adverse incident reporting of the residents continual elopements. Resident # 9's diagnoses included , and . The resident's health assessment section (D) revealed, the physician did not verify whether the resident ' s individual needs could be met in an Assisted Living Facility, which is not a medical, nursing or facility. During these elopements, the resident has been without the medications prescribed for his diagnoses.

Review of the resident ' s Medication Record revealed, the resident is prescribed medications as follows Benzotropine MES 1 mg by mouth, 1 mg by mouth, SOD DR 500 mg by mouth, 10 mg by mouth, 30 mg by mouth, and 600

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A 025	Continued From page 2	A 025		

mg tab by mouth. Review of the resident ' s medication observation record for and 2013 revealed, the resident was not given his prescribed medications , 2013 to , 2013 and , 2013 to , 2013.

Failure to take Benzotropine as directed can lead to muscles spasm stiffness tremors, sweating, drooling and poor muscle control. It is used to treat and prevent symptoms caused by the medication Fluphenanize which is used to treat such as . The resident is currently prescribed to take twice daily to control abnormal or disturbing thoughts and emotions. Warnings on this medication states you should not stop taking it abruptly as is can lead to serious adverse reactions such as , hallucinations, muscle spasm, speech difficulty, sleep disturbance and nightmares. Failure to take as directed can lead to increased . Failure to take can lead to increased as well as .

Record review of resident #9 ' s observation log documents on , 2013 at 2:00 pm, the facility called the police department to report resident # 9 had left the facility on , 2013 and had not returned. On , 2013 at 10:30 am, the facility called the police department to report that resident #9 had returned to the facility. Employee A, found resident #9 in the street and returned him to the facility. Police officers returned to the facility and gave her the police department case number. Employee A documented, resident #9 was currently sleeping in his .
During an observation of the facility on , 2013 at 4:00 pm, it was noted the resident had not returned to the facility and had verbalized to

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staff that he was going to visit friends in Miami Beach. During an observation of the facility on , 2013 at 2:00 pm, it was noted resident #9 still had not returned to the Assisted Living Facility (ALF). The staff reported, the resident has not returned from his friend ' s house. The staff member reported during this observation, when the resident returns to ALF, she will communicate his return to his social worker.

Continued review of the residents observation log revealed, the residents was not present at the facility on , 2013 to , 2013. This was a total of 14 days. As of , 2013, the resident is still missing and the facility did not know the location of the resident.

Interview with resident #9 ' s Case Manager and Registered Nurse on , 2013 at 1:12 p.m., it was reported the resident was missing a week ago. He is supposed to live in Happiness ALF. We recently opened his case but he has been missing. I have been calling all the hospitals and the Morgue and he is still missing. Resident #9 has been using drugs and living on the street since he was , . He was on Jail diversion, since the last days of and the court dropped all his charges. The resident was found walking naked on the street and that is why he was on the jail diversion. After they dropped the charges the resident left the ALF. We are looking at putting him in a program for drug . We opened his case at the end of , 2013. He is not at the facility and we are looking for him. He is without medications and using drugs and . He uses crack and marijuana. The last report was from the ALF administrator, he told us he likes to go Miami Beach to hang out with friends. I actually went to the ALF this morning, I spoke with the kitchen staff. She told

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me, he was not there. The Psychiatrist saw him 1 or 2 times. We haven't seen him since the court dropped the case.

Record review of resident #9's Assisted Living Facility with Limited Mental Health License Community Living Support Plan, dated 2013, section #3, documents the responsibilities of the facility to assist the resident in attending appointments (e.g. arranging transportation to appointments and activities) and additional supports: service-provide/monitoring medications and compliance's, provide three balanced meals, provide adequate living arrangement for one year according with AHCA regulations. The plan goes on to document, the resident needs to visit a counselor every week for one year.

During record review, it was noted Resident #9 did not have any documentation in his file for being an elopement risk, the facility failed to follow its Elopement policy which states: All residents assessed at risk for elopement or with a history of elopement shall be identified so staff can be alerted to their needs for support and supervision. There is no documentation in the residents file to show what the facility staff would do in case of an elopement. As a part of its resident elopement response policies and procedures, facility shall make, at a minimum, a daily effort to determine that at risk residents has identification on their persons that includes their names 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. An

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immediate staff search of the facility and premises. Evidence of this procedure being followed was not documented in the facility ' s files. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement and response policies and procedures which the facility failed to maintain in any type of documentation.

The facility policy and procedure documented, the facility ' s definition of Elopement is an occurrence in which a resident leaves a facility without following facility policy and procedures.

(Policies and procedures are a set of documents that describe an organization's policies for operation and the procedures necessary to fulfill the policies. They are often initiated because of some external requirement, such as environmental compliance or other governmental).

Response to a resident elopement, Preventive measures:
1. Develop a method to identify residents who are a risk for elopement, such as known wanders.

2. Implement appropriate interventions for each resident ' s who have been identified as being high risk. These could include:
* Keeping behavior logs;
* maintaining supervision and periodic checks, as possible;
* conducting ongoing activity programs to minimize aimless wandering tendencies;
* securing exit doors with alarms or electric locks

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A 025	Continued From page 6 with keypads with results * installing fenced yard controls, along with staff supervision; * training staff on appropriate response to account for residents immediately. 3. Once a resident has been identified at risk for elopement and preventive interventions have been implemented, communicate this to everyone involved in the resident's care, beginning with; * The resident's care plan, which should list all interventions that are used to prevent an elopement. * Assignment sheets indicating to all direct-care staff which- residents are at risk for elopement and what interventions are needed to prevent this. During interview with the administrator on , 2013 at 4:00 pm, it was reported the resident has always left the facility and returned, but as of , 2013, the resident was still missing from the facility. 2. Interview on , 2013 at 11:00 am, with the caregiver on duty(staff member A), it was reported she heard the residents screaming upstairs in their about 1:30 am. She reported, resident #8 showed her a condom earlier that evening and stated that he was going to someone that night before going to his the night. That night, resident #8 attempted to follow through with his threat and tried to assault his resident #1, but did not complete his on the . After being observed by the caregiver, resident # 8 became angry at the caregiver because of the observation and being stopped before completing the on the roommate.	A 025		

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A 025	Continued From page 7 Staff member A, did not report resident #8 ' s threat to the administrator or contact resident #8 ' s physician until after the attempted assault took place. Review of resident #1's record revealed, resident #8 attempted to him during the night of 27, 2013, while he was sleeping in his bed. Resident #8 was caught by the night staff trying to assault resident #1. The documentation revealed, resident #1 began to scream get off me very loud and staff member A heard both of the residents yelling from upstairs, where they both slept. Staff member A ran upstairs and saw resident #8 touching resident #1 from behind. The staff member yelled for him to stop what he was trying to do to resident #1. She then grabbed resident #1 and they ran down stairs to hide resident #1 from the (resident #8). The caregiver then called the local Police and the owner-administrator. Resident #8 started throwing things around his the police arrived to the facility. The health assessment for resident #1 revealed diagnoses of: / / GERDS/ /Moderate / . Record review revealed resident #8 was on , 2013 around 1:30 am, the night of the attempted assault. Resident # 8 ' s health assessment documented diagnoses of: /GERDS/ NOS. Class 1	A 025		
A 030 SS=J	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES.	A 030		

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(a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C.
(b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
(c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.
(d) The statewide toll-free telephone number of the Florida Hotline " 1(800)96- or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices,

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schedules, and requirements.
(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.
(g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.
(h) Pursuant to Section 429.41, F.S., the use of physical shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from and neglect.

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(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a [illegible] his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.

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(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.
(k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

This Statute or Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to provide a safe and decent living environment, free from and neglect.

The Findings included:

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Review of resident #1's record revealed, resident #8 attempted to him during the night of 27, 2013, while he was sleeping in his bed. Resident #8 was caught by the night staff trying to assault resident #1. The documentation revealed, resident #1 began to scream get off me very loud and staff member A heard both of the residents yelling from upstairs, where they both slept. Staff member A ran upstairs and saw resident #8 touching resident #1 from behind. The staff member yelled for him to stop what he was trying to do to resident #1. She then grabbed resident #1 and they ran down stairs to hide resident #1 from the (resident #8). The caregiver then called the local Police and the owner-administrator. Resident #8 started throwing things around his the police arrived to the facility. The health assessment for resident #1 revealed diagnoses of: / / GERDS/ /Moderate / . Record review revealed resident #8 was on 2013 around 1:30 am, the night of the attempted assault. Resident # 8 ' s health assessment documented diagnoses of: /GERDS/ NOS.
During an interview with Resident #1 on 2013 at 10:34 AM, the resident reported he was awakened by resident #8 (his at the time) trying to him. He stated, he began to scream, " get off me " very loud.

During an interview on , 2013 at 11:00 am with the caregiver on duty, she stated, she heard the resident ' s screaming upstairs in their at about 1:30 am. She stated, resident #8 had showed her a condom earlier that evening and stated that he was going to someone that night before going to his the night. That

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night he attempted to follow through with his threat and tried to assault his resident #1, but he did not complete his on resident #1, his . Resident #8 became angry at the caregiver because of the observation and being stopped before completing the on the .

During an interview with resident #17 on , 2013 at 1:35 pm, revealed resident #17 stated that he awoke to go to the heard a noise from Resident #1 and resident #8 ' s . Resident #1 was in the bed and resident #8 was leaning over him telling him he was going to him. That is when I pulled Resident #1 and #8 apart. There was no staff upstairs at that time. The night staff did not come until later that night. Resident #1 then ran out of the thanked him for saving him from the .

Interview with the administrator on at 4:00, stated that staff member A the caretaker who worked the night shift called him to tell him what had happened at the facility during her shift. He stated, the night staff member told him that resident #8 his and tried to have intercourse with him. The police were called and resident #8 was due to becoming physically violent towards residents. The employee and administrator both stated, resident #8 told her he was going to someone later that night. The administrator stated that staff member A told him that resident #8 showed her a condom and made the statement he was going to someone that night. The Administrator also stated that he was going to contact resident #9's social worker in regards to getting rid of him because resident #9 did not follow the rules of the facility in regards to coming back the facility on time when he goes out

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	AL11953412	A. BUILDING: _____ B. WING _____	

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A 030	Continued From page 14 into the community and when he tells staff he would return. Record review did not have a 45 day notice in the residents file. The police department provided information that resident #8 was because he became physically violent towards other residents and staff. Resident #8 was taken to a local hospital. Class I	A 030		
A 054 SS=D	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider ' s name, the resident ' s name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known the resident may have; the name of the resident ' s health care provider, the health care provider ' s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered. (c) For medications which serve as chemical , the facility shall, pursuant to Section	A 054		

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A 054	Continued From page 15 429.41, F.S., maintain a record of the prescribing physician ' s annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview the assisted living facility failed to ensure that 1 out of 17 (#9) sampled residents medication observation records (MORs) were initialed daily. Findings include: Record review found that resident #9's medication observation record for the month of was left blank from the evening of to . Record review found that the facility documented that resident #9 left on and had not returned; they reported him missing on to the Hialeah Police Department. Record review found that the facility did not initial resident #9's MOR daily when he was missing to indicate that he had not taken his medications. Interview with resident #9's social worker on at 1:12 p.m. revealed that he had been missing from the facility since of end of . Class III	A 054		
A 077 SS=J	58A-5.019(1) FAC Staffing Standards - Administrators Staffing Standards. (1) ADMINISTRATORS. Every facility shall be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents as required by Part I of Chapter 429,	A 077		

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A 077	Continued From page 16 F.S., and this rule chapter. (a) The administrators shall: 1. Be at least ; 2. If employed on or 15, 1990, have a high school diploma or general equivalency diploma (G.E.D.), or have been an operator or administrator of a licensed assisted living facility in the State of Florida for at least one of the past 3 years in which the facility has met minimum standards. Administrators employed on or after , 1995, must have a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening standards pursuant to Section 429.174, F.S.; and 4. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C. (b) Administrators may supervise a maximum of either three assisted living facilities or a combination of housing and health care facilities or agencies on a single campus. However, administrators who supervise more than one facility shall appoint in writing a separate " manager " for each facility who must: 1. Be at least ; and 2. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C. (c) Pursuant to Section 429.176, F.S., facility owners shall notify both the Agency Field Office and Agency Central Office within ten (10) days of a change in a facility administrator on the Notification of Change of Administrator, AHCA Form 3180-1006, 2006, which is incorporated by reference and may be obtained from the Agency Central Office. The Agency Central Office shall conduct a background screening on the new administrator in accordance with Section 429.174, F.S., and Rule 58A-5.014, F.A.C.	A 077		

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This Statute or Rule is not met as evidenced by:
Based on record review and interview, the assisted living facility's administrator failed to demonstrate that he supervised the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents specifically those with limited mental health. This affected 3 of 10 sampled residents.

The Findings include:

The facility's administrator failed to set in place measures that would ensure that limited mental health residents received adequate care and supervision. Record review found that the facility's administrator failed to ensure that resident #9 who had a history of elopement received adequate supervision and the facility's elopement policies were followed. Record review found that the facility documented that resident #9 left the facility on , but it was not reported to law enforcement till . Resident #9 was observed missing from the facility on , but the facility did not call law enforcement to report him missing. The facility's administrator has failed to ensure that resident #9 was supervised properly and failed to ensure that the facility followed its elopement policy and procedures in reference to calling law enforcement immediately after a resident is found missing. Although the facility and the administrator was aware that resident #9 would leave the facility for days at a time, there were never any policies or additional personal care offered to resident #9.

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A 077	Continued From page 18 Record review found that since resident #9 was out of the facility from to and then left again on he was without his medications for , and , . Record review found that resident #9 had not taken the following medications: Benzotropine MES 1 mg tab to be taken 2 x's daily @ 8 am/8 pm 1 mg tab to be taken @ 8 am/8 pm SOD DR 500 mg tab to be taken @ 8 am 10 mg tab to be taken 2's daily @ 8 am/8 pm/ 30 mg cap to be taken @ 8 pm 600 mg tab 3's daily to be taken @ 8 am/4 pm/8 pm (PRN). The administrator stated on at 4:00 p.m., that he knows that the resident likes to leave the facility and return. He stated he wanted to get rid of the resident cause he was too much trouble but there was no 45 day notice in the record. The administrator could not provide any information as to why the facility failed to provide additional supervision to resident #9. It was determined during a visit to the facility on , resident #9 was still missing from the facility and the facility did not know his location. The facility's administrator failed to ensure that the facility's staff members were supervised and trained in investigating resident complaints and statements regarding incidents that have occurred or will occur. Interview with staff member A in the presence of the facility's administrator on at 11:00 a.m. (administrator translated from Spanish to English) revealed that she was told by resident #8 that he was going to someone and resident #8	A 077		

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A 077	Continued From page 19 showed her a condom. The administrator did nothing as far as any disciplinary actions towards staff member A who failed to report an act of violence to law enforcement. The administrator did not have any documentation that he spoke to staff member A regarding the correct way to deal with a resident telling her that he would conduct an act of violence. Record review found that the facility did not have any documentation that staff member A contacted the administrator to inform him of resident #8's statement or that she investigated resident #8's statement. Record review found that resident #1 and resident #8 were involved in an attempted alleged assault on at around 1:30 a.m. in the morning. After the facility was made of aware of the situation regarding residents #1 and #8, the facility administrator did not conduct any in-service training with staff. The facility also did not have any documentation that showed that the administrator completed an internal investigation regarding the alleged attempted that occurred between residents #1 and #8. Information provided by the police department revealed that resident #8 was because he became physically violent with the other residents and staff member A at the facility. Class I	A 077		
A 079 SS=J	58A-5.019(4) FAC Staffing Standards - Levels (4) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities shall maintain the following minimum staff hours per week: Number of Residents Staff Hours/Week	A 079		

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0-5 168
6-15 212
16-25 253
26-35 294
36-45 335
46-55 375
56-65 416
66-75 457
76-85 498
86-95 539

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

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

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

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

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

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

7. The administrator or manager ' s time may be counted for the purpose of meeting the required staffing hours provided the administrator is actively involved in the day-to-day operation of

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A 079	Continued From page 21	A 079		

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

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A 079	Continued From page 22 notification, of a corrective action plan indicating how the increased staffing is to be achieved and resident service needs will be met. The plan shall be reviewed by the agency to determine if the plan will increase the staff to needed levels and meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, modifications may be made in staffing requirements for the facility and the facility shall no longer be required to maintain a plan with the agency. 3. Based on the recommendations of the local fire safety authority, the Agency may require additional staff when the facility fails to meet the fire safety standards described in Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the Agency that fire safety requirements are being met. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of Rule 58A-5.029, 58A-5.030, or 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observations, record review, and interview, the facility failed to ensure they were able to provide care and services to meet the needs of 26 residents. The facility failed to have enough qualified staff members to provide or	A 079		

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arrange for resident services in accordance with the residents scheduled and unscheduled service needs and resident care standards. The facility failed follow its written staffing pattern.

The Findings included:

Upon arrival to the facility on at 10:45 a.m. three staff members were observed at the facility which included the cook and two staff members working for a census of 26 residents. The staffing pattern for the facility was posted on the bulletin board in the dining . There were four staff members scheduled to work on for the morning shift, but observations found only three staff members at the facility. The facility's administrator was out of the country, although the facility's staffing pattern showed that he was scheduled to work 9am-6pm Monday to Friday (, 2013 to , 2013).

The week of , the facility had two major incidents which involved residents which could have been prevented if the facility provided more personal supervision to the residents specifically their mental health residents. Record review found, the facility documented that resident #9 was missing on and that same week, record review found that residents #1 and #8 were involved in an alleged attempted assault on .

Resident #1 stated on at 2:20 p.m. that resident #8 his came to him at 1:30 in the morning on showed him a condom and stated "I'm going to , you". This event could have been prevented because earlier that day staff member A stated on at 11:00 a.m. that "resident #8 came to her and showed her a condom, he stated that he was going to

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A 079	Continued From page 24	A 079		

someone". The resident stated that only staff member A was at the facility that night and she took him to the dining locked him in there until the police came because resident #8 became very violent.

Record review found that only one staff member was working the morning of . Staff member A was unable to supervise the other residents once resident #8 became violent to the other residents including herself. The facility was unable to provide services to meet the needs of the residents during this major event which placed all the other residents at the facility in harm's way.

Record review found that staff timesheets for the week of to had the following:
Administrator- 94 hours per week, the administrator does not have any documentation regarding how much time is used as administrative versus time providing care to residents.
During 7am-5pm shift- Medication Technician/ Cook 70 hours per week, the facility does not have documentation of how many of the 70 hours are given to providing care to the residents.
During 6am-3pm shift- Cook 65 hours per week (excluded from care staff hours).
During 7am-2pm shift- 42 hours per week.
During 3pm-11pm shift-60 hours per week.
During 11pm-7pm shift- 56 hours per week this staff member covers when workers are off- 28 hours per week.

The facility failed to provide documentation that showed at least one staff member was awake at all times during the night. The facility's communication log documented on the night of at 1:00 (possibly AM) "total

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A 079	Continued From page 25 ok". The facility does not have any documentation from staff member A that she conducted on both floors during her shift and checked on the residents that night at the facility. The facility failed to have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents scheduled and unscheduled service needs and resident care standards. Class I	A 079		
A 165 SS=D	429.23 FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, " adverse incident " means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. [illegible]; 2. [illegible] or spinal damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to	A 165		

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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 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

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
	AL11953412	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAPPINESS CARE CENTER II, INC	1105 W 2ND AVENUE HIALEAH, FL 33010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 165	Continued From page 27 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 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, 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	A 165		

Agency for Health Care Administration

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A 165	Continued From page 28	A 165		

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 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 for a missing resident as well as reported .

Findings includes:

1. Record review revealed resident # 9 has left the facility on several occasions (due to lack of facility documentation actual dates and time frame cannot be verified) without returning for days at a time. A police report with a (case number) was completed on , 2013, yet the Agency for Health Care Administration (AHCA) was never notified via adverse incident reporting of the resident ' s continued elopements.

Additional record review of resident #9 ' s observation log documents on , 2013 at 2:00 pm facility called police department to report resident # 9 had left the facility on and

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A 165	Continued From page 29	A 165		

had not returned. On @ 10:30 am, facility called Hialeah Police department to report that resident #9 had returned to the facility and employee A stated that she found him in the street and returned him to the facility. Police came back to the facility and gave her the case number. She stated that resident #9 was currently sleeping in his . . . . . On , 2013 at 4:00 pm, the resident has not returned to the facility and had verbalized to staff that he was going to visit friends in Miami Beach. On , 2013 at 2:00 pm resident #9 continued to not report to the ALF, he has not returned from his friend ' s house. When he returns to the ALF, I(employee) will communicate it to his social worker.

2. Review of resident #1's record revealed that resident #8 attempted to assault him during the night of , 2013, while he was sleeping in his bed. Resident #8 was caught by the night staff trying to assault resident #1. He stated he began to scream " get off me " very loud and staff member A heard both of the residents yelling from upstairs where they both slept. She stated that she ran upstairs and saw resident #8 touching resident #1 from behind. She yelled for him to stop what he was trying to do to resident #1. She then grabbed resident #1 and they ran down stairs to hide resident #1 from the . . . . . (resident #8). She then called the Hialeah Police and the owner-administrator. That is when resident #8 started to throwing things around his the police arrived to the facility. The health assessment for resident #1 revealed
Diagnoses of: . .
/ / GERDS/ /Moderate
. . . . . / . . . . . Record review revealed
resident #8 was on around 1:30 am the night of the assault. Resident # 8

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A 165	Continued From page 30 health assessment : _ , _ _ /GERDS/ , NOS. During an interview with Resident #1 on , 2013 at 10:34 AM, the resident reported he was awakened by resident #8 (his at the time) trying to him. He stated, he began to scream, " get off me " very loud. During an interview on , 2013 at 11:00 am with the caregiver on duty, she stated, she heard the resident ' s screaming upstairs in their about 1:30 am. She stated, resident #8 had showed her a condom earlier that evening and stated that he was going to someone that night before going to his the night. That night he attempted to follow through with his threat and tried to assault his resident #1, but he did not complete his on resident #1, his . Resident #8 became angry at the caregiver because of the observation and being stopped before completing the on the . There was no documentation that the facility completed the necessary documentation via adverse incident reports to notify the AHCA of these occurrences. During an interview with the owner/administrator on at 3:00 pm, he confirmed the findings, he did not file the 1 day and the 15 day adverse incident reports timely. Class III	A 165		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Happiness Care Center II, Inc
1105 W 2nd Avenue
Hialeah, FL 33010

Re: CCR #2013005805

Dear Administrator:

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. Additional information will be provided regarding the status of your license.

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,

Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone (305) 593-3100; Fax (305) 593-3121