STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910713	02/05/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
New Hope Group Home	6021 Duval Street Hollywood, FL 33024	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:
0008-Admissions - Health Assessment
0081-Training - Staff
0090-Training -

Revisit Repeat Tags:
0010-Admissions - Continued Residency-58a-5.0181(4) Fac
0079-Staffing Standards - Levels-58a-5.019(4) Fac
0165-Risk Mgmt & Qa; Adverse Incident Report-429.23 Fs; 58a-5.0241 Fac

Specific Tag Findings:

0000-Initial Comments
An Assisted Living Facility relicensure revisit survey was conducted on New Hope Group Home had uncorrected licensure deficiencies found at the time of the visit.

Note: Complaint survey CCR #2013011151 was conducted in conjunction with the relicensure survey revisit. Please refer to the separate report.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on observation, record review and interviews, the facility failed to ensure that 1 out of 7 sampled residents (Resident#1) was appropriately evaluated for readmission.

The findings include:

Review of Resident #1's record, revealed a Health Assessment (AHCA form 1823) dated documenting that the resident has a diagnosis of Further review of the form revealed the resident's or behavioral status was documented as

Further review of the record revealed a note indicating that on at 12:00 PM, Resident #1 walked out of the yard, law enforcement was called to report a missing person; law enforcement called back to report that the resident was found and was at the hospital. Resident #1 returned to facility on at 2:00 PM. Resident #1 at 8:00 PM , began screaming at a female resident (Resident #6) and choked her, the Administrator "rescued her, called rescue, police and rescue personnel came". Resident # 1 was taken to hospital where he was A review of the involuntary forms revealed the resident was due to violent behavior; the resident attempted to choke a resident at the Assisted Living Facility. The form documents the resident's diagnosis as: , Behavioral and

A record review of the Hospital Behavioral Health Psychosocial Assessment Update Note dated for Resident # 1, revealed the following. Resident #1's current diagnosis includes:
a) Axis I-
b) Axis II-Deferred
c) AxisIII- , Behavioral
d) Axis Primary Support group problems, Social and Environmental problems and Housing Problems
e) Axis V- 11-20: Some danger of hurting self and others, possible or occasionally fails to maintain minimal personal hygiene or gross in communication.

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The current living situation is addressed and states that per Assisted Living Facility (ALF) staff and resident's family member, the resident is not allowed to return to the ALF due to violent outburst. According to the family member the Resident's Case Manager is working to identify a facility that offers a higher level of care. The hospital Discharge Plan dated revealed that Resident #1 was discharged back to the ALF he came from.

In an interview conducted with the Administrator on at approximately 2:00 PM , she stated that on Resident #1 was placed under a and spent 7 days in the hospital for his behaviors and the incident involving another resident. She also stated that the resident has been given a 45 day notice of discharge, due to him requiring a higher level of care and that his case manager has been advised and that they are looking for a new placement for him. A request for a copy of the 45 day notice was made and upon review of the notice, it was noted the notice was a handwritten document dated stating the following. "I am giving you 45 days notice. You can leave the facility as soon as possible because of your behavior". As of the resident still resides at the facility. The Administrator stated they cannot find a place to put him.

During a telephone interview at approximately 3 PM on with Resident #1's Case Manager, she stated Resident # 1 has behavioral issues when his medications need to be adjusted; he requires supervision at night. She has been his case worker for the last 2 years. She states she is aware that he eloped and was Baker-Acted in 2013. She states they are trying to find another facility for this resident because he is low functioning, has behaviors and requires supervision but they have not had any luck.

Class III
Uncorrected from

0079-Staffing Standards - Levels 58A-5.019(4) FAC
Based on record review and interview, the assisted living facility failed to maintain a written work schedule to reflect its actual 24-hour staffing pattern for a given time period.

The findings Include:

Observation made on at 8:50 AM, of the staffing schedule posted on the wall (dated 2013) documented 2 scheduled employees (Employee #1 and #4 (the Administrator). Employee #1 who identified herself as the housekeeper was the only staff member present upon arrival at 8:30 AM on She stated she works 2 hrs a day from 8:30 AM-10 AM as the housekeeper.

The Administrator arrived at the facility at 9:50 AM on A copy of staffing schedule was requested. The Administrator provided a scheduled for the month of 2014, which was not posted. The scheduled was reviewed with the Administrator at 10:15 AM on Review of the staff schedule with the Administrator revealed she was documented to work on noted day from 6 AM-12 PM, she stated she was running late. The Administrator stated she was also responsible for assisting the residents (Resident #1-#7) with their medications for that morning. However, she once again revealed she was "running late". Review of the medication observation records (MORs) did not identify any of the 7 residents had received their 7 AM medications. Further review of the 2014 staffing pattern schedule, revealed the night shift (6 PM to 6 AM) for the month was staffed by either Employee #3 or Employee #2. Review of the schedule revealed Employee #3 was scheduled to work the prior night During an interview with the Administrator at 10:25 AM on regarding who worked at the facility last night and to request an interview with them; she stated they are not available because the father is in the hospital. The Administrator at this time, did not say who was covering for

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the employee.
During an interview at 11:20 AM on with Employee #2 (direct care giver), he stated the Administrator comes to the facility anytime between 7 AM and 10 AM ; she does not have a set schedule. He further stated " At night we do not stay here (at the facility) we are next door, if there is a problem they can come next door to get us". He stated after 9 PM or 10 PM nobody sleeps here. He stated , that in the past there may have been 1 or 2 incidents where residents have gone out at night but not often. Employee #2 was questioned at this time, regarding the supervision at the facility and how they provide supervision to the residents if they are not present in the facility. Employee #2 was unable to state how they supervise the residents at night and confirmed that the scheduled staff (Employee #2 and #3) do not stay in the house with the residents overnight. He stated they (Employee #2 and #3) are relatives of the Administrator who live in the house next door to the facility

Further observations conducted during the survey revealed Employee #1 had left the facility. During an interview 11:45 AM on with the Administrator, she stated Employee #1 left at 11:00 AM on noted date. The Administrator confirmed the employee was scheduled to work until 12 PM. The Administrator was not able to provide an explanation for the scheduling conflicts.

Class III
Uncorrected from

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on record review and interview, the facility failed to file an adverse incident report as required, for 1 of 2 (Resident #1) records reviewed.

The findings include:

Review of Resident #1's record, revealed a Health Assessment (AHCA form 1823) dated documenting that the resident has a diagnosis of Further review of the form revealed the resident's or behavioral status was documented as

Further review of the record revealed a note indicating that on at 12:00 PM, Resident #1 walked out of the yard, law enforcement was called to report a missing person; law enforcement called back to report that the resident was found and was at the hospital. Resident #1 returned to facility on at 2:00 PM. Resident #1 at 8:00 PM , began screaming at a female resident (Resident #6) and choked her, the Administrator "rescued her, called rescue, police and rescue personnel came". Resident # 1 was taken to hospital where he was A review of the involuntary forms revealed the resident was due to violent behavior; the resident attempted to choke a resident at the Assisted Living Facility. The form documents the resident's diagnosis as: , Behavioral and

In an interview conducted with the Administrator on at approximately 2:00 PM , she stated that on , Resident #1 was placed under a and spent 7 days in the hospital for his behaviors and the incident involving another resident. The Administrator confirmed that she did not file an adverse incident report and that Resident #1 was placed under a and spent 7 days in the hospital.

Class III
Uncorrected from

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
New Hope Group Home
6021 Duval Street
Hollywood, FL 33024

RE: CCR #2013011151 and Relicensure Revisit Survey

Dear Administrator:

This letter reports the findings of a complaint inspection survey and a relicensure revisit survey conducted on 5, 2014, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, State (5000-3547) Form, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D
St - A - L243 - 58a-5.0191(8) Fac - Lmh - Training S-S= D

Directed Corrective Actions:

1. The Assisted Living Facility is required to ensure that a staff member is present at the facility (on grounds) at all times, reflecting 24 hour staff coverage.

2. The Assisted Living Facility is required to develop and maintain an accurate monthly staffing schedule, reflecting the daily staffing pattern for each staff member. This schedule should reflect a 24 hour staffing pattern.

3. The Assisted Living Facility is required to ensure that all staff members receive a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses.

4. The Assisted Living Facility is required to evaluate all current residents (Resident #1-#7) to ensure continued residency criteria is met and that the facility is able to meet the care needs of each resident (including supervision).

1. The Assi Living Facility is required to discharge any resident that no longer meets the continued residency criteria immediately.

2. The Assisted Living Facility is required to complete an adverse incident report for Resident #1 (incident that occurred on and submit to the Agency.

3. The Assisted Living Facility is required to develop and establish a monitoring plan to ensure all adverse incidents are properly evaluated (documented) and required documents submitted to the Agency within the required timeframe (1 adverse incident report & 15 day adverse incident report).

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call Catherine Anne Avery, Survey and Certification Support Branch at (850) 412-4505 or Tikel Wedges-Phoenix, Health Facility Evaluator Supervisor at (561) 381-5846.

Sincerely,

T. Wedges-Phoenix, Supervisor

Arlene Mayo-Davis
Field Office Manager

MD/ls
Enclosure

Received by: Rebecca Thomas Adm.
Administrator/Representative Title

Date Hand Delivered: 3/11/2014