| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11967998 | 07/10/2014 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| Diversity Me | 3225 N Myrtle Ave Jacksonville, FL 32209 | |
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**List of Tags Cited:**
St - A - 0000 - - Initial Comments
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= J
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0031 - 58a-5.0182(7) Fac - Resident Care - Third Party Services S-S= D
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= J
St - A - 0151 - 58a-5.023(2) Fac - Physical Plant - Existing Facilities S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= G

**Specific Tag Findings:**

**0000-Initial Comments**
An unannounced complaint survey involving two separate complaints, CCR#2014004892 and CCR# 2014005423, was conducted at Diversity Me in Jacksonville, Florida on , 2014. Licensure deficiencies were identified as a result of the survey.

**0008-Admissions - Health Assessment 58A-5.0181(2) FAC**
Based on record review and staff interview, the facility failed to ensure that a current and complete resident health assessment was maintained in the resident's clinical record for 2 of 6 residents sampled. (Residents #2 and #3)

The findings include:

A review of the clinical record for Resident #2 revealed that the resident health assessment was incomplete. There was no documentation specifying whether Resident #2 required assistance with medication self-administration. Page 4 was missing the following information: the examiner's printed name, address, telephone number, the examiner's title, and the date that the exam was completed. (Photographic evidence obtained)

A review of the clinical record for Resident #3 revealed that the resident health assessment was incomplete. There was no documentation specifying whether Resident #3 required assistance with medication self-administration. Page 1 of the health assessment under the headings Nursing/Treatment/ and Special Precautions was left blank, and no diet was specified. Page 2 was missing information indicating whether Resident #3 required 24-hour nursing or supervision. Page 4 was missing the address and telephone number of the examiner. (Photographic evidence obtained)

During a interview with the administrator at approximately 11:40 a.m., she stated that she was unaware that the health assessments for Residents #2 and #3 were incomplete.

Class III

**0025-Resident Care - Supervision 58A-5.0182(1) FAC**
Based on interview and record review, the facility failed to provide adequate supervision for the whereabouts of 2 of 3 sampled residents (Resident #1, #2) and failed to notify Resident #1 and Resident #2's the case manager that they were missing from the Assisted Living Facility.

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The findings include:

1) On at 11:20 AM an Interview with the administrator revealed Resident #1 had a doctor appointment and Community Rehabilitation Center (CRC) provided transportation to the appointment. He went to Duval County Health Department (DOH). Resident #1's appointment was at 1-2:00 PM on , 2014. The Administrator said she was not at the facility when CRC came to pick him up. The administrator stated that Resident #1 did not return from his appointment. She said she received a call from Employee D at 9:00 AM on the following day after the appointment ( , 2014). The administrator said Employee D reported to her that he knew Resident #1 was out of the facility, but because he isn't considered an elopement risk he did not worry. She stated, Employee D did not notify her of Resident #1's elopement until the morning of , 2014, after the DOH called the facility. The administrator reported that she did not file an adverse incident report with the Agency for Health Care Administration. She stated the adverse incident was not completed because Resident #1 did not get injured. The Administrator stated that an elopement is reported to AHCA only if a residents was harmed or injured. She confirmed she did not contact the case manager for Resident #1 or Resident #2 for either elopement.

On at 11:30 AM an interview with the Community Rehabilitation Center, Director of Operations revealed someone called him from the facility and asked to provide transportation for Resident #1 to the appointment only. He reported that neither he nor the company were called to pick Resident #1 up from the appointment. He said he dropped Resident #1 off at his appointment and did not stay with him. He said he was not told the resident needed someone to be with him at his appointment. He stated he found out the next day, Resident #1 did not return to the facility. He said the Administrator called him and he went to pick up Resident #1 from the DOH, around 9-9:30 am on , 2014.

On at 11:54 AM an interview with Employee B revealed the date of Resident #1's doctor appointment was , 2014 at 1:00 PM. She said CRC transportation came and picked him up between 12:15-12:30 PM. She said no one went with him to his appointment because he did not need an escort. She said before she left work on , 2014 she told the next shift to call when Resident #1 came home. Employee B said upon arrival the next morning at 7:30 AM she was told Resident #1 did not return that night. She said the DOH called at 8:00 AM to report that Resident #1 was still at the DOH building and that he had stayed on the bench all night. She said she did not document in the Resident Observation Log the occurrence of Resident #1 missing for the night of , 2014.

On at 12:48 PM a telephone interview with Employee D revealed he worked the night of , 2014.. He said when he arrived to work he noticed Resident #1 wasn't in his bed. He said he is not a wanderer, and thought Resident #1 was with his family. He said he called Employee B but she didn't answer the phone. He said when the morning came, the DOH called and said Resident #1 was at the DOH all night. He said he was not aware he went to an appointment that day. Employee D said when a resident is missing he is supposed to call his supervisor. He reported he did not call his supervisor, just Employee B.

On at 1:13 PM an interview with Resident #1 was conducted upon arrived from the center. He revealed he went to a doctor appointment on , 2014 and he stayed outside the office building all night. He said he never slept that night. Resident #1 said he stayed on the bench the whole night. He said someone was supposed

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to come and pick him up, but they never came.

Record review of the facility's "Wander Form" revealed that the form is used to assess all residents as to determine who is at risk as a wanderer. The form revealed that in the event the resident should become lost, the facilities elopement drill will be followed.

Record review of the Wander Form for Resident #1 signed on . The form was checked that Resident #1 was determined to be a wanderer. Review of elopement policy for Resident #1 was signed on . (photographic evidence obtained)

2) On at 1:07 PM an interview with the administrator revealed Resident #2 left the facility "sometime after Christmas 2013." She said she did not file a report to the Agency for Health Care Administration regarding the resident eloping. She also stated she did not contact the resident ' s case manager or notify the police after Resident #2 did not return. She said she does not know where Resident #2 went, but she never returned. The administrator said "I discharged her from the facility on 1st, 2014 because Resident #2 never returned."

A record review for Resident #2 revealed an admission date of . She was diagnosed with . Resident #2's Resident Health assessment read that the resident required supervision with medication.

In a telephone interview with the Investigator at the State Attorney's office on at 9:15 AM, he reported that Resident #2 was reported missing to the Jacksonville Sheriff's Office by her sister. He reported that as of the date and time of the phone interview, law enforcement has been unable to locate Resident #2.

The facility's Elopement Policy read that the purpose of the policy was to establish guidelines in the event an elopement occurs and what should be done if a resident returns after an elopement. Upon discovery of a missing resident a staff member will notify the administrator. The administrator will alert the resident ' s representative. The policy read that the Administrator and the resident's representative will determine of JSO (Jacksonville Sheriff's Office) will be notified.

Record review of the facility's "Wander Form" for Resident #2 revealed that the form was signed on . The form was checked that Resident #2 was determined to be a wanderer. Review of the elopement policy for Resident #2 was signed on 3/29/2011.(photographic evidence obtained)

Class I

**0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS**
Based on observation, record review, and interview, the facility failed to ensure that residents were provided the ability 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 for 1 of 6 sampled residents. (Resident #4) The facility also failed to ensure that the address and telephone number for lodging complaints against the facility or facility staff was posted in full view in a common area accessible to all residents.

The findings include:

1) During a complaint investigation conducted on , the administrator was asked whether Resident #4

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was alert and oriented. The administrator stated at approximately 11:35 a.m. that Resident #4 was as functional as she (The Administrator) was. She stated that Resident #4 could easily convey her wants and needs.

A review of Resident # 4's clinical record revealed that it was completed and signed by the Advanced Registered Nurse Practitioner (ARNP) on . Resident #4 was diagnosed with "Schizo". Her /behavioral status was documented as "no". She was identified as independent with all activities of daily living.

An interview with Resident #4 on Friday, at 12:05 p.m. during her day program revealed the following: When asked whether she remembered a representative from a third party service coming out to see her in her home, she replied, "Yes I do." When asked whether she would describe what happened when that party visited, Resident #4 stated, No, I can't. The owner doesn't want me to talk about that." "The owner told me I don ' t need his services. They kind of got into an argument." Resident # 4 was observed to be alert and oriented, and clean and well-kempt during the interview. She was able to answer questions appropriately, and maintained good eye contact.

A interview with the administrator at 11:01 a.m. revealed that she had no policy and procedure related to third party services. She stated, "I don't have no home health come in here, so no. I never heard of that. No, I don ' t have that." When asked whether anyone representing a third party service had come to the facility within the last three months to speak with any of her residents, the administrator denied that anyone had visited. She stated, "No. No one has come here; not while I was here."

2) Upon entering the facility on at 9:00 a.m., Employee C was asked for the admission and discharge log. Employee C stated that she was unable to access the log as it was locked in the administrator's office, and she didn't have a key. Employee C stated that the administrator would provide it when she arrived.

During a tour of the facility on at approximately 9:30 a.m., telephone numbers for the purpose of lodging a complaint about the facility or the facility staff were not observed in any of the facility's common areas. The administrator's office door was observed to be closed and locked.

An interview with the administrator at approximately 11:45 AM revealed that she kept all emergency numbers in her office on a bulletin board, because the residents would "tear them down" otherwise. The administrator stated that she had an open door policy, and that the residents could go into her office anytime to obtain the number. The administrator stated that staff members had access to the administrator's office. The administrator stated that Employee C "could have opened the door. She just had to stick a knife in it. I leave the door open, but sometimes the residents close and lock the door."

Class III

**0031-Resident Care - Third Party Services 58A-5.0182(7) FAC**
Based on record review and staff interview, the facility failed to develop and maintain a policy and procedure related to third party services. This potentially affected all 16 residents living in the facility.

The findings include:

During a complaint survey conducted on , no policy and procedure related to third party services was identified during the facility records review.

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A review of the facility's "House Rules" revealed that there was no mention of anything related to third party services. (Photographic evidence obtained)

A interview with the administrator at 11:01 a.m. revealed that she had no policy and procedure related to third party services. She stated, "I don't have no home health come in here, so no. I never heard of that. No, I don ' t have that." When asked whether anyone representing a third party service had come to the facility within the last three months to speak with any of her residents, the administrator denied that anyone had visited. She stated, "No. No one has come here; not while I was here."

Class III

**0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC**
Based on interview and record review th facility failed to conduct an immediate search and failed to notify law enforcment for 2 of 3 missing sampled residents and failed to follow facility policy for elopement. (Resident #1 and #2)

The findings include:

1) On at 11:20 AM an Interview with the administrator revealed Resident #1 had a doctor appointment and Community Rehabilitation Center (CRC) provided transportation to the appointment. He went to Duval County Health Department (DOH). Resident #1's appointment was at 1-2:00 PM on , 2014. The Administrator said she was not at the facility when CRC came to pick him up. The administrator stated that Resident #1 did not return from his appointment. She said she received a call from Employee D at 9:00 AM on the following day after the appointment ( , 2014). The administrator said Employee D reported to her that he knew Resident #1 was out of the facility, but because he isn't considered an elopement risk he did not worry. She stated, Employee D did not notify her of Resident #1's elopement until the morning of , 2014, after the DOH called the facility. The administrator reported that she did not file an adverse incident report with the Agency for Health Care Administration. She stated the adverse incident was not completed because Resident #1 did not get injured. The Administrator stated that an elopement is reported to AHCA only if a residents was harmed or injured. She confirmed she did not contact the case manager for Resident #1 or Resident #2 for either elopement.

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On at 11:54 AM an interview with Employee B revealed the date of Resident #1's doctor appointment was , 2014 at 1:00 PM. She said CRC transportation came and picked him up between 12:15-12:30 PM. She said no one went with him to his appointment because he did not need an escort. She said before she left work on , 2014 she told the next shift to call when Resident #1 came home. Employee B said upon arrival

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the next morning at 7:30 AM she was told Resident #1 did not return that night. She said the DOH called at 8:00 AM to report that Resident #1 was still at the DOH building and that he had stayed on the bench all night. She said she did not document in the Resident Observation Log the occurrence of Resident #1 missing for the night of , 2014.

On at 12:48 PM a telephone interview with Employee D revealed he worked the night of , 2014.. He said when he arrived to work he noticed Resident #1 wasn't in his bed. He said he is not a wanderer, and thought Resident #1 was with his family. He said he called Employee B but she didn't answer the phone. He said when the morning came, the DOH called and said Resident #1 was at the DOH all night. He said he was not aware he went to an appointment that day. Employee D said when a resident is missing he is supposed to call his supervisor. He reported he did not call his supervisor, just Employee B.

On at 1:13 PM an interview with Resident #1 was conducted upon arrived from the center. He revealed he went to a doctor appointment on , 2014 and he stayed outside the office building all night. He said he never slept that night. Resident #1 said he stayed on the bench the whole night. He said someone was supposed to come and pick him up, but they never came.

Record review of the facility's "Wander Form" revealed that the form is used to assess all residents as to determine who is at risk as a wanderer. The form revealed that in the event the resident should become lost, the facilities elopement drill will be followed.

Record review of the Wander Form for Resident #1 signed on . The form was checked that Resident #1 was determined to be a wanderer. Review of elopement policy for Resident #1 was signed on . (photographic evidence obtained)

2) On at 1:07 PM an interview with the administrator revealed Resident #2 left the facility "sometime after Christmas 2013." She said she did not file a report to the Agency for Health Care Administration regarding the resident eloping. She also stated she did not contact the resident ' s case manager or notify the police after Resident #2 did not return. She said she does not know where Resident #2 went, but she never returned. The administrator said "I discharged her from the facility on 1st, 2014 because Resident #2 never returned."

A record review for Resident #2 revealed an admission date of . She was diagnosed with . Resident #2's Resident Health assessment read that the resident required supervision with medication.

In a telephone interview with the Investigator at the State Attorney's office on at 9:15 AM, he reported that Resident #2 was reported missing to the Jacksonville Sheriff's Office by her sister. He reported that as of the date and time of the phone interview, law enforcement has been unable to locate Resident #2.

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Office) will be notified.

Record review of the facility's "Wander Form" for Resident #2 revealed that the form was signed on . The form was checked that Resident #2 was determined to be a wanderer. Review of the elopement policy for Resident #2 was signed on 3/29/2011.(photographic evidence obtained)

Class I

**0151-Physical Plant - Existing Facilities 58A-5.023(2) FAC**
Based on observation and staff interview, the facility failed to comply with building code 434.4.5.1 which requires one working tub or shower per 8 residents. This had the potential to effect all 16 residents residing at the facility.

The findings include:

A full was observed with a broken shower fixture. At approximately 10:05 a.m., Employee C stated that "They all shower upstairs." (Photographic evidence obtained)

A review of the upstairs a small standing shower that was approximately 3 feet by 3 feet. There were no other working showers or bathtubs located in the facility.

Class III

**0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC**
Based on observation and interview, the facility failed to provide a safe living environment, free of hazards, ensuring that all existing architectural, mechanical, electrical, and structural systems and appurtenances were maintained in good working order. The facility failed to maintain linens which were free of stains, failed to maintain a duplicate set of keys to resident to be used in the event of an emergency, and the facility failed to maintain adequate lighting.

The findings include:

During a tour of the facility on at approximately 9:30 a.m., the following concerns were identified:

The upstairs as belonging to Resident #1 was observed with an overhead light which didn't work, a smoke alarm was and hanging by the wires from the ceiling, the dresser drawers were broken and would not slide in and out, there were no night stands or lamps, the window screens were ripped, and the door knob was broken. (Photographic evidence obtained)

The upstairs as belonging to Resident #6 had no overhead light. One lamp was observed unplugged and sitting on the closet floor. The ceiling fan was not affixed to ceiling safely. The window screens were ripped. A black cord was observed pulled from outside through the window, with the window closed over it. The door knob was not affixed to door properly. (Photographic evidence obtained)

A interview with the administrator at 10:58 a.m. revealed the following: When asked her about the black cord coming through the window upstairs, she replied that it was a cable cord.

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An upstairs [redacted] to an unsampled resident was observed with an overhead light that did not work. There was no other light source in the [redacted]. A chain lock was observed on the inside of the door. The door hinge was broken. An interview with Employee B at 1:00 p.m. revealed that 'most of the residents' lights were removed, because they leave the lights on 24 hours a day, or they'll get up there and play with the lights until they break them.' (Photographic evidence obtained)

The [redacted] was equipped with a small shower (no tub), a toilet and a sink. The counter top was not affixed to the vanity. There were no towels, toilet paper or soap available. The [redacted] of sewage. The shower was observed with significant build up, and did not appear to have been cleaned recently. A large stack of cardboard was observed in the [redacted]. Employee C stated at 9:43 a.m. that the toilet paper was kept in the kitchen. She said that if a resident needed toilet paper for the [redacted], they had to ask a staff member to get it for them. (Photographic evidence obtained)

An upstairs [redacted] to an unsampled resident was observed with a window looking out onto a business parking lot. The window was nailed shut. There was no screen or window covering for privacy. There was a hole in the wall where a light switch should be. The armoire had a padlock on it, and Employee C was unable to open the armoire. She was unable to find a key that fit. She stated at 9:41 a.m. that the resident could not unlock it either, because "He will mess up his clothes" An interview with Employee B at approximately 12:33 PM revealed that the staff had to keep the resident's armoire locked, because "He'll take off his pamper and smear feces on the walls." (Photographic evidence obtained)

Several [redacted] belonging to unsampled residents on the upper level were locked. No one answered and Employee C stated that the residents were out at their day programs. At approximately 9:50 a.m., when asked whether Employee C was able to open the doors, she replied that she could not. She stated that the residents were alert and oriented, and that they were the only ones with keys to the doors.

A [redacted] belonging to an unsampled resident had an entry door that locked but was broken. Turning the door knob did not open the door. Employee C stated at approximately 10:00 a.m. that the door could be opened even if it was locked just by "pushing" it.

Class III

**0165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC**
Based on record review and interview the facility failed to, submit an adverse incident report for resident elopement to the Agency for Health Care Administration for 2 of 3 sampled residents (Resident #1, #2).

The findings include:

1) On [redacted] at 11:20 AM an Interview with the administrator revealed Resident #1 had a doctor appointment and Community Rehabilitation Center (CRC) provided transportation to the appointment. He went to Duval County Health Department (DOH). Resident #1's appointment was at 1-2:00 PM on [redacted], 2014. The Administrator said she was not at the facility when CRC came to pick him up. The administrator stated that Resident #1 did not return from his appointment. She said she received a call from Employee D at 9:00 AM on the following day after the appointment ([redacted], 2014). The administrator said Employee D reported to her that he knew Resident #1 was

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out of the facility, but because he isn't considered an elopement risk he did not worry. She stated, Employee D did not notify her of Resident #1's elopement until the morning of , 2014, after the DOH called the facility. The administrator reported that she did not file an adverse incident report with the Agency for Health Care Administration. She stated the adverse incident was not completed because Resident #1 did not get injured. The Administrator stated that an elopement is reported to AHCA only if a residents was harmed or injured. She confirmed she did not contact the case manager for Resident #1 or Resident #2 for either elopement.

On at 11:30 AM an interview with the Community Rehabilitation Center, Director of Operations revealed someone called him from the facility and asked to provide transportation for Resident #1 to the appointment only. He reported that neither he nor the company were called to pick Resident #1 up from the appointment. He said he dropped Resident #1 off at his appointment and did not stay with him. He said he was not told the resident needed someone to be with him at his appointment. He stated he found out the next day, Resident #1 did not return to the facility. He said the Administrator called him and he went to pick up Resident #1 from the DOH, around 9-9:30 am on , 2014.

On at 11:54 AM an interview with Employee B revealed the date of Resident #1's doctor appointment was , 2014 at 1:00 PM. She said CRC transportation came and picked him up between 12:15-12:30 PM. She said no one went with him to his appointment because he did not need an escort. She said before she left work on , 2014 she told the next shift to call when Resident #1 came home. Employee B said upon arrival the next morning at 7:30 AM she was told Resident #1 did not return that night. She said the DOH called at 8:00 AM to report that Resident #1 was still at the DOH building and that he had stayed on the bench all night. She said she did not document in the Resident Observation Log the occurrence of Resident #1 missing for the night of , 2014.

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On at 1:13 PM an interview with Resident #1 was conducted upon arrived from the center. He revealed he went to a doctor appointment on , 2014 and he stayed outside the office building all night. He said he never slept that night. Resident #1 said he stayed on the bench the whole night. He said someone was supposed to come and pick him up, but they never came.

Record review of the facility's "Wander Form" revealed that the form is used to assess all residents as to determine who is at risk as a wanderer. The form revealed that in the event the resident should become lost, the facilities elopement drill will be followed.

Record review of the Wander Form for Resident #1 signed on . The form was checked that Resident #1 was determined to be a wanderer. Review of elopement policy for Resident #1 was signed on .

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
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| | **AL11967998** | **07/10/2014** |
| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| **Diversity Me** | **3225 N Myrtle Ave Jacksonville, FL 32209** | |
| SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION) | | |

(photographic evidence obtained)

2) On at 1:07 PM an interview with the administrator revealed Resident #2 left the facility "sometime after Christmas 2013." She said she did not file a report to the Agency for Health Care Administration regarding the resident eloping. She also stated she did not contact the resident ' s case manager or notify the police after Resident #2 did not return. She said she does not know where Resident #2 went, but she never returned. The administrator said "I discharged her from the facility on ', 2014 because Resident #2 never returned."

A record review for Resident #2 revealed an admission date of . She was diagnosed with . Resident #2's Resident Health assessment read that the resident required supervision with medication.

In a telephone interview with the Investigator at the State Attorney's office on at 9:15 AM, he reported that Resident #2 was reported missing to the Jacksonville Sheriff's Office by her sister. He reported that as of the date and time of the phone interview, law enforcement has been unable to locate Resident #2.

The facility's Elopement Policy read that the purpose of the policy was to establish guidelines in the event an elopement occurs and what should be done if a resident returns after an elopement. Upon discovery of a missing resident a staff member will notify the administrator. The administrator will alert the resident ' s representative. The policy read that the Administrator and the resident's representative will determine of JSO (Jacksonville Sheriff's Office) will be notified.

Record review of the facility's "Wander Form" for Resident #2 revealed that the form was signed on . The form was checked that Resident #2 was determined to be a wanderer. Review of the elopement policy for Resident #2 was signed on 3/29/2011.(photographic evidence obtained)

Class II

residents cannot be located by this time, the elopement policy and procedure must be utilized. The form and documentation that staff has been trained in its utilization should be presented with your plan of correction.

8) The facility must complete the Agency for Health Care Administration's adverse incident report for Resident #1 and Resident #2.

9) The facility must develop a communication log that clearly documents communication between facility staff and resident case managers. The communication log must to be used when residents have a change in condition as defined in Florida Administrative Code 58A-5.0131 and anytime a resident elopes. The form and documentation that staff has been trained in its utilization should be presented with your plan of correction.

Nothing in this Directed Plan of Correction limits the Agencies authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call . Kim Smoak, Survey and Certification Support Branch, at 850-412-4516.

Sincerely,

Jana L. Meyering, Q.I.D.P.
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JD/JM/RED/sm

leaving the facility and her whereabouts cannot be determined. Resident #1 & Resident #2's case managers were not informed of the change in status.

3) A0165- Adverse Incident Reporting- Class II
The Assisted Living Facility failed to file an adverse incident report when Resident #1 and Resident #2 were missing from the facility and their whereabouts were unknown. This resulted in Resident #1 being left outside the Department of Health overnight. It resulted in Resident #2 leaving the facility and her whereabouts cannot be determined. Resident #1 & Resident #2's case managers were not informed of the change in status.

Your plan of correction must include the following, which you are directed to implement as indicated below:

1) Develop policy and procedures for elopement. The policy and procedures must include a definition of elopement, who to contact when an elopement occurs (including case managers, family and local law enforcement) and instructions on completing an adverse incident report for the Agency for Health Care Administration. The elopement policy and procedure must meet all criteria under Florida Administrative Code 58A-5.0182 (8). A copy of this policy and procedure should be presented with your plan of correction.

2) The facility must contact the local law enforcement agency and report Resident #2 as missing from the facility since , 2014. This contact must be documented in the resident's record.

3) Provide In-Service training for all staff regarding the new policy and procedure for elopement. The in-service training must be documented as being completed after and should be presented with your plan of correction.

4) The facility must run elopement drills every month. Every staff must participate in the elopement drills. The documentation of those drills must be sent to the field office for review, monthly, for no less than a minimum of 6 months. You must obtain written permission from AHCA to stop providing notifications to AHCA.

5) In-Service training for all staff regarding resident supervision as it pertains to Florida Administrative Code 58A-5.0182(1). The in-service must have an agenda and must be completed after .

6) The facility must develop a form to be utilized by staff of each shift which identifies the whereabouts of each resident living at the facility. The form shall be completed no less than 3 times a day. The form must ensure the documentation by staff that every resident has been observed no less than once every eight (8) hours. This form and documentation that staff has been trained in its utilization should be presented with your plan of correction.

7) The facility must develop an appointment log wherein each day of the week reflects any resident appointments for that day. The appointment log must specify the responsible party for transportation of the resident both to and from the appointment. Staff must sign off that all residents are back from appointments, no later than 6PM on the day of the appointment. If

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

Tiki Stafford
Diversity Me
~~1220 Jimmy Ann Dr.~~ 3225 N. Myrtle Ave
~~Daytona Beach, FL 32117~~ Jacksonville, FL 32209

Dear Mrs. Stafford:

This letter reports the findings of a biennial licensure survey conducted on , 2014 by a representative of the Agency for Health Care Administration. Attached is the provider's copy of the State (5000) Form, which indicates there were deficiencies noted during the inspection.

You are hereby directed to provide a written plan of correction to the Jacksonville Field Office for the deficiencies identified during the inspection, within five calendar days of receipt of this directed plan of correction (DPOC). The plan should be directed to the attention of Mrs. Jana Meyering, Health Facility Evaluator and mailed to:

Agency for Health Care Administration
Health Quality Assurance, Jacksonville Field Office
Attention: Jana Meyering, QIDP
921 N. Davis Street, Bldg. A, Suite 115
Jacksonville, FL 32209
Phone: (904) 798-4201
Fax: (904) 359 - 6054

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

1) A0025- Resident Supervision- Class I

The Assisted Living Facility failed to have a general awareness of Resident #1 and Resident #2's general whereabouts. This resulted in Resident #1 being left outside the Department of Health overnight. It resulted in Resident #2 leaving the facility and her whereabouts cannot be determined. Resident #1 & Resident #2's case managers were not informed of the change in status.

2) A0032- Elopement Standards- Class I

The Assisted Living Facility failed to follow their elopement policy for Resident #1 and Resident #2. The facility failed to report to law enforcement and the agency that Resident #1 and Resident #2 were missing from the facility and their whereabouts were not known. This resulted in Resident #1 being left outside the Department of Health overnight. It resulted in Resident #2