STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910969	06/12/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
JESUS OF NAZARETH ALF, INC	2801-2803 SW 37TH COURT MIAMI, FL 33134	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

A Complaint (CCR#2015005952) Inspection Survey was conducted on . Jesus of Nazareth Assisted Living Facility had the following deficiencies.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on interviews and record review, the facility failed to provide adequate care and supervision for one of twelve Residents (Resident #1.) The resident left the facility repeatedly without staff knowledge or effective intervention upon his return. The resident ' s last such absence ended in his on , after he was struck by a car 0.1 miles away from the facility.
Findings:
On , a review of police reports and Emergency Medical Services reports revealed that Resident #1 on as a result of his injuries after he walked into traffic and was struck by a car 0.1 miles away from the facility.
On , a review of Resident #1 ' s record revealed that he had walked away from the facility without notifying staff on 2 consecutive days (and) before his .
On at 1:22 p.m., The Administrator stated that " He started going out and not letting anyone know. I sat down with him the first time he did it, and he said ' forgive me, forgive me. ' He was following the rules when he came from the rehab center and he was weak. When he saw that he could walk, we saw that problem. "
A review of the resident record revealed that there was no evidence of increased staff supervision of Resident #1 after the unauthorized absences on and .
On a review of Resident #1 ' s record revealed that the resident ' s health care providers were not notified of a change in the resident ' s behavior nor was a new assessment sought after he walked away from the facility without notice on and .
On at 1:23 p.m., the Administrator stated that on " with a patient like that it ' s difficult to monitor him twenty four hours a day. We didn ' t realize he left. "
On at 1:24 p.m., the Administrator stated that the resident lived in a the facility ' s back door. He stated that the resident was last seen on . The Administrator stated that the resident went to bed at around 6:00 p.m. However he acknowledged that the resident ' s Medication observation record (MOR) is initialed by staff, indicating that the resident took 7:00 p.m. and 8:00 p.m. medications. Staff did not look in the resident ' s this until a neighbor came at 10:28 p.m. to tell them about a nearby car accident.
On record review revealed that after a neighbor came by at around 10:28 p.m. on to tell the facility staff that someone had been struck by a car nearby, the staff searched the facility and found that the resident was missing. The facility did not report the resident ' s absence to the police.
Class II

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on interviews and record review, the facility failed to implement elopement measures protect one of twelve residents with demonstrated elopement history (Resident #1) after the resident eloped twice. The facility did not follow its own policies and procedures regarding elopement or ensure that Resident #1 had a photo identification

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0032 Continued From page 1

and the facility address on his person after he was identified as an elopement risk. These failures contributed to the resident ' s on /
Findings:
On , a review of police and Emergency Medical Services reports revealed that Resident #1 was pronounced at 11:23 p.m. on as a result of his injuries when he was hit by a car after walking into traffic.
On , a review of Resident #1 ' s record revealed that he had walked away from the facility without notice and without staff knowing his whereabouts on 2 consecutive days (and) before the day of the accident.
On at 1:22 p.m., The Administrator stated, regarding Resident 1 ' s elopement on , that " When he did it the first time, I told him I was going to start reporting these incidents. "
A review of Resident #1 ' s record revealed that after the resident ' s first elopement on / at 6:00 p.m., the Administrator explained to the resident that he needed to notify the facility staff before leaving. No other intervention was made to supervise the resident.
A review of Resident #1 ' s record revealed that he eloped again on . The Administrator explained to the resident that he needed to notify the facility staff before leaving. No other intervention was made to supervise the resident.
A review of the facility ' s Wandering & Elopement Policy & Procedures revealed that routine reassessments were to be conducted to determine changes in mental status or behavior.
A review of Resident #1 ' s record found no documentation that a reassessment of the resident ' s mental status or behavior was conducted.
On at 1:23 p.m., the Administrator stated that Resident #1, who moved into the facility on / , did not have any identification, and the facility did not have a picture of the resident.
A review of Resident #1 ' s record revealed a photocopy of the resident ' s Veteran ' s Administration (VA) Identification card which contained a space for a photograph. There was no documentation that the facility staff contacted the VA to obtain an updated photo identification card which contained a photo.
A review of the Emergency Medical Services, police records and hospital records of the / accident revealed that the resident was identified as ' John Doe ' when he was taken to hospital. No identification of the resident ' s address was on his person. A bus card found on the resident did not assist with his identification. The resident was only able to be identified by a picture from prior hospital records and fingerprint records from Miami Police Department.
On record review revealed that after a neighbor came by at around 10:28 p.m. on to tell the facility staff that someone had been struck by a car nearby, the staff searched the facility and found that the resident was missing. The facility did not contact law enforcement or file an adverse incident report regarding the resident ' s absence.
On at the Administrator stated that he drove around the neighborhood shortly after 10:28 p.m. after staff notified him that Resident #1 was missing, but that he did not see any signs of an accident.
A review of the police report revealed that the accident occurred at 9:48 p.m. on , 0.1 miles away from the facility, at SW 37 Court and SW 27 Lane. According to the report, the accident scene was cleared at 1:40 a.m. on
Class II

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0053 Continued From page 2

0053 - Medication - Administration - 58A-5.0185(4) FAC

The facility failed to ensure that a licensed staff was available to provide medication administration for one of twelve sampled residents (Resident #2). An unlicensed staff (Staff #A) was placing medications into the resident ' s mouth.
Findings:
On / at 2:07 p.m. the Administrator stated regarding Resident #2 " We put the medication in her mouth to give it to her. She ' s not able to put them in her mouth herself. " He further stated that he is a Registered Nurse but he does not administer the resident ' s medication because he is not usually at the facility when it is time for her to take them. He stated that Staff # A administers the medication, and that Staff # A is not licensed. He also stated that Hospice is not administering the resident ' s medication.
On at 3:40 p.m., Resident #2 ' s Hospice Caregiver stated that Hospice is not providing medication administration for the resident.
Record review revealed that the Medication Observation Record for Resident #2 was signed twice daily by Staff #A for the month of 2015 and for 1-9, 2015.
Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation, interview and record review, the facility failed to maintain an accurate staff schedule.
Findings:
On / at 1:00, Staff # B and Staff #C were observed working at the facility.
A review of the staff schedule revealed that Staff #s A and C were scheduled to be working on at 1:00.
On , a review of records of the incident on resulting in Resident #1 ' s revealed that Staff #B was scheduled to be on duty.
On at 1:30 p.m. the Administrator stated that Staff #A was on duty on even though the schedule listed Staff #B was working. He stated that there was no record of who actually worked in the facility on any day since the staff sometimes traded shifts, or worked to cover someone who was out sick. The Administrator acknowledged that the facility did not keep accurate staff schedules.
Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interview and record review, the facility failed to file an Adverse Incident Report for three elopements preceding the of 1 of 12 Residents (Resident #1).
Findings:
A review of the facility ' s policy reveals that " Elopement refers to an unauthorized absence of a resident from the facility. The policy further states that " The police will be notified as soon as it has been determined that the resident is not in the facility. "
A review of Resident #1 ' s record revealed that the resident eloped on , and . There was no

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0165 Continued From page 3

documentation that the police were notified.
A review of the AHCA Incident Report Database revealed that no report was filed for any of Resident #1 ' s elopements.
On [redacted] at 1:22 p.m., the Administrator acknowledged that the facility failed to file a police report or an Adverse Incident Report about these elopements, stating that he was not aware of the requirement to do so.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

Mr. Orlando Muniz, Administrator
Jesus of Nazareth Assisted Living Facility
2801 S.W. 37TH COURT
MIAMI, FL 33134

Dear Mr. Muniz,

This letter reports the findings of a licensure complaint survey (CCR# 2015005952) conducted on ', 2015 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.

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

1) St-A0025- Class II- Resident Supervision

The facility failed to provide appropriate supervision, care, and services for Resident #1 after he eloped from the facility twice. Resident #1 l as a result of his injuries when he was hit by a car after walking into traffic during his third elopement from the facility.

2) St-A0030- Class II- Resident Care: Elopement Standards

The facility failed to implement elopement measures to protect one of twelve residents with demonstrated elopement history (Resident #1) after the resident eloped twice. The facility did not follow its own policies and procedures regarding elopement or ensure that Resident #1 had a photo identification and the facility address on his person after he was identified as an elopement risk. These failures contributed to the resident's l on

You are directed to complete the following tasks:

1) The facility must conduct effective elopement assessments immediately on all current residents, and on all future residents upon admission. A new assessment must be conducted on all residents within 24 hours of any change of behavior where a resident demonstrates wandering or elopement behaviors. The elopement assessments must be completed by a staff who is fully trained in the facility's elopement procedures and who is qualified to make an accurate evaluation of the resident's elopement risk.

The written assessment, and documentation of follow up actions taken as a result of the assessment to ensure the residents' safety, signed by the person conducting it, must be kept on kept on file at the facility, and be available for review by the Agency.

2727 Mahan Drive • Mail Stop #
Tallahassee, FL 32308
AHCA.MyFlorida.com

921 North Davis Street, A-125
Jacksonville, Florida 32209
(904) 798-4201
Fax (904) 359-6054

If any resident demonstrates wandering or elopement behaviors, the facility must contact the resident's health care providers and collaborate regarding the course of care. This contact and course of care must be documented in the resident's file.

2) The facility must implement a written, detailed plan of how to provide interventions for any resident's wandering or elopement behaviors. The plan must include the interventions to address the behaviors. It must also document how concerns and the plan to address them are brought to the attention of all staff. It must also state how interventions are documented and followed up on in a timely manner. This plan must include a timeframe for documenting the concern after it is observed or reported and a timeframe for when the follow up action will occur. The plan must identify the parties responsible for conducting the follow up.

   This plan must be developed and implemented by . All employees must be trained on the plan, no later than . The plan and documentation of staff training must be kept on file at the facility and available for review by the Agency.

3) The facility must implement a specific process for ensuring that all residents who are identified as having wandering or elopement behaviors have a picture in their file. Such residents should also have photo identification and the facility's contact information on their person within 72 hours of admission to the facility or a change in behavior or condition which identifies them as a wandering or elopement risk.

4) The facility must complete in-service training for all staff regarding resident supervision as it pertains to Florida Administrative Code 58A-5.0182(1). The training must have an agenda and sign-in sheet and must be completed by . The in-service must be kept on file at the facility and available for review by the Agency.

Any required documentation set forth above which is not to be maintained on site and/or in resident records, should be directed to the attention of Mrs. Laura Manville, Operations and Management Consultant or Mrs. Kristal Branton, Health Facility Evaluator Supervisor and sent to:

Agency for Health Care Administration
Health Quality Assurance, Miami Field Office
Attention: Kristal Branton
8333 NW 53 St, Suite 300
Miami, FL 33166
Phone: (305) 593-3106
Fax: (305) 593 - 3121

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 .. Laura Manville, Survey and Certification Support Branch, at 727-552-1955 or Verlande Exil, Miami Field Office, at 305-593-5100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Jesus Of Nazareth Alf, Inc
2801-2803 Sw 37th Court
Miami, FL 33134

RE: CCR #2015005952

Dear Administrator:

This letter reports the findings of a Complaint Survey that was conducted on , 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe.

Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Kristal Branton, Health Facility Evalautor Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

Enclosure
XG90

Miami Field Office
8333 N.W. 53rd Street, Suite 300
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