STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969174	R 10/31/2017
NAME OF PROVIDER OR SUPPLIER **NEW ERA COMMUNITY HEALTH CENTER LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1351 N KROME AVE** **HOMESTEAD, FL 33030**	

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

0000 - Initial Comments

A Complaint Revisit Survey was conducted on 10/18/2017 and concluded on 10/31/2017. New Era Community Health Center Llc. (License # 12989) with Limited Mental Health component had the following deficiencies identified at the time of the survey:

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

Based on record review and interview the facility failed to provide appropriate supervision to meet the needs of three out of ten sampled residents, in order to prevent residents from eloping and wandering out of the facility. This failure resulted in three of 10 sampled residents being injured and hospitalized for serious health conditions (Residents #1, #2, and #3). Resident #1 eloped twice within three weeks.

Findings Included:

1) A review of Resident #1's notes revealed the resident eloped on and was found by the police and hospitalized. The resident had no identification on him, and the police could not notify the facility that he had been found until they identified him by other means. Resident #1 eloped again on and was found by the police in a park, unresponsive due to , and having broken arm bones, repaired by surgery (left shaft , left radial shaft , and left radial neck). Resident #1 was hospitalized on the ( ), and because he bore no identification on his person, he had to be identified by his fingerprints.

A review of Resident #1's hospital record received on revealed the resident was found in the local area with and left deformity. Resident #1 was transferred to area, nonverbal, with no eye contact, following simple commands. Upon his workup, Resident #1 was found to have a left of the radial an . The plan was to admit the patient to the while mental status was under evaluation. The patient was in , the patient was finger printed in attempts to identify the patient as no family has presented for the patient. On , , 2017, the patient was identified and proxy was found. The patient underwent surgery with Orthopedic Hand group for repair of the left shaft . Left radial shaft , and left radial neck .

A review of the facility's incident report for Resident #1 documented on at 6:30 AM Staff H went to find Resident #1 to assist with self-administering his morning (AM) medications. Staff H was not able to find Resident #1. She proceeded to contact the facility's Administrator. The Administrator immediately reported to work and started to phone all area hospitals in an attempt to locate Resident #1. The Administrator called local authorities to locate the resident. The police reported to site and wrote a missing person report.

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A review of Resident #1's file showed the resident was admitted to the facility on . Resident #1's health assessment dated revealed a medical history and diagnoses of , , , , , and Unspecified without , , . Physical or sensory limitations: Awake alert and oriented x 3. or behavioral status: , . Nursing/treatment/ , service requirement: None, per health assessment the resident is an elopement risk. The resident needs supervision with all activities of daily living (ADL). The resident needed assistance with self-administration of medications.

On at 12:11 PM the Owner reported, "Resident #1 went missing on , the Staff H went to assist with self-administering medications in the morning (about 6:30 AM) and she found out the resident was missing. He was found the same day at the clinic and he was taken to the hospital, from there he was discharged but I decided not to take him back to the facility. No I did not give him a 45 day notice."

2) A review of Resident #2's notes revealed the resident eloped on and the Administrator found him in a park on after his aunt called the facility's owner to say that he might be there. Although the resident was missing there was no documentation or indication that he was checked by a doctor.

A review of the facility's incident report for Resident #2 documented on Friday showed that the resident did not report to lunch. The Administrator went to locate the resident and was unable to find him. The facility's Administrator was contacted. He notified the resident's case manager at the day program.

On at 10:39 AM the Administrator reported Resident #2 eloped, stating he left from the program on . The Administrator stated "We found out because the staff did not see him at 12:00 PM that same day. On I found him at a park in Hialeah because two weeks later his aunt who informed me that Resident #2 might me at this park in Hialeah."

A review of Resident #2's file showed the resident was admitted on . Resident #2's health assessment dated revealed a medical history and diagnosis of , . Physical or sensory limitations: Awake, Alert, Oriented x 3. The health assessment documented that Resident #2 was an elopement risk. The resident needed supervision with all ADL. The resident needed assistance with self-administration of medications.

On //2017 at 1:22 PM observed Resident #2 did not have identification with him or an elopement

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bracelet or identifier on his person after the resident had gone missing on . Resident #2 stated "I went to Hialeah to visit my aunt, and the owner found me at a park in Hialeah close to my aunt's house. I was just hanging out with my friends."

3) A review of Resident #3's notes revealed the resident eloped on and was found by the police on , on the front lawn of a private home. The homeowners brought Resident #3 water and called emergency medical services ( ). He was taken to the hospital, where he was diagnosed with rhabdomyolysis with acute kidney injury, secondary to volume depletion (According to the Centers for Control, rhabdomyolysis is a medical condition associated with heat stress and prolonged physical exertion, resulting in the rapid breakdown, , and of muscle. When muscle tissue dies, and large proteins are released into the bloodstream that can cause irregular rhythms and , and damage the kidney). He was found to have extreme and had generalized and malaise, having attempted to walk from the ALF to the mall (26 to 29 miles away from the ALF).

A review of Resident #3's hospital record received on revealed the resident stated he walked for an entire night without drinking water from his ALF attempting to reach international mall and passed out in a driveway. He states that he " himself." Onset: The symptom(s)/episode began occurred last night. Severity of symptoms: in the emergency department the symptoms have improved markedly. It is unknown whether or not the patient has had similar symptoms in the past. Patient states that he was fed up with his ALF and that the food would give him , so he decided to go to the mall where he could be homeless and receive air conditioning, water and teriyaki. He states that he has never attempted to do this before. reports that he was found in the front yard of a home. During Interview, the patient stated that his father , 8 years ago. According to , he stated he was walking to the mall to meet his father there.

On at 1:23 PM the Owner reported, "Resident #3 was missing on . Staff J went to give him his medications in the morning. The police called on and reported the resident was found because of a disturbance" in a city nearby. "The Police brought the resident back to the facility."

On at 1:00 PM observed Resident #3 to have identification with him but did not have any information about the facility's name or address, or other elopement identifiers, on his person.

A review of Resident #3's file showed he was admitted on . Resident #3's health assessment dated revealed a medical history diagnoses of ( ), , , (BPD), and , Chronic Type ( ). or behavioral status: He had a history of , and , . Nursing/treatment/ , service requirements:

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Medication management, group , , , and activities , , , . Per health assessment Resident #3 was an elopement risk. The resident was independent with all ADL. The resident needed assistance with self-administered medication.

A review of the facility's incident report for Resident #3 documented on Staff I went to assist with self-administering night (PM) medications. Upon arrival the resident was not in his . Staff I search the facility's campus. Staff I contacted the facility's Administrator to notify him of the problem.

On at 1:00 PM Resident #3 stated "I wanted to go to the restaurant, I stayed there and I started to ask people for a ride to the mall or to the hospital, but the police was called they told me I was being a disturbance."

4) Record review revealed the facility did not have any policies and procedures in place to prevent residents from eloping. The facility also did not have any documentation on providing additional supervision to Residents #1. #2, and #3 after the residents had eloped and were hospitalized when they were located outside the facility.

A review of the facility's elopement policy documented steps to:
1. Check residents three time a day during shift change, to make sure resident is present.
2. If resident is not at the facility the administrator or the president within 24 hours will contact authorities to do
   a police report.
3. The facility will notify AHCA within 24 Hours after police report has been filed.
4. Staff will continue to call all Hospitals to see if patient has been admitted.

On at 10:45 AM Staff D stated "I have been working here since , of this year, if we have a person that eloped we call the owner and we start looking for the resident. None of the residents have left, not while I have been here. If a resident has an emergency we have to call the emergency department."

On at 10:50 AM Staff E stated, "I have been here almost three months, no I have never witnessed a resident elope. We received the training, if a resident is missing, we have been told we will start looking for the resident and call the owner and call 911. We also started doing rounds every two hours."

On at 10:56 AM Staff F stated "I have been here for 6 months. I have not witnessed a resident elope or . The first thing to do would be to Call 911, second is to look for the resident, and let

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the owner know and call 911."

On at 11:01 AM Staff G stated "I have been working here since , /2017, during my shift I have not witness a resident elope. If the resident is missing to look for him and to contact the owner."

Class II

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

Based on record review and interview the facility failed to have detailed written elopement policies and procedures.

Findings included:

A review of the facility's elopement policy documented the following:
1. Check residents three time a day during shift change, to make sure resident is present.
2. If resident is not at the facility the administrator or the president within 24 hours will contact authorities to do
   a police report.
3. The facility will notify AHCA within 24 Hours after police report has been filed.
4. Staff will continue to call all Hospitals to see if patient has been admitted.

The facility's policies and procedures did not state the facility would complete a search of the facility and premises and did not identify which staff members who would be responsible for implementing parts of the elopement policies and procedures.

Record review revealed the facility did not follow it's elopement policies and procedures after Residents #1, #2, and #3 had eloped from the facility in .

On at 10:45 AM Staff D stated "I have been working here since , of this year, if we have a person that eloped we call the owner and we start looking for the resident. None of the residents have left, not while I have been here. If a resident has an emergency we have to call the emergency department."

On at 10:50 AM Staff E stated, "I have been here almost three months, no I have never witnessed a resident elope. We received the training, if a resident is missing, we have been told we will start looking for the resident and call the owner and call 911. We also started doing rounds every two hours."

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On at 10:56 AM Staff F stated "I have been here for 6 months. I have not witnessed a resident elope or . The first thing to do would be to Call 911, second is to look for the resident, and let the owner know and call 911."

On at 11:01 AM Staff G stated "I have been working here since , /2017, during my shift I have not witness a resident elope. If the resident is missing to look for him and to contact the owner."

Class III