STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911829	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL PALACE RESIDENTIAL,	4491 SW 8 STREET MIAMI, FL 33134

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

A complaint survey (CCR #s 2017014045 and 2017013803) was conducted from through . Central Palace Residential, License # 7107, with Limited Mental Health and Limited Nursing services components, had the following deficiencies identified at the time of the visit:

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

Based on interview, record review, and observation the facility failed to provide care and supervision appropriate to the needs of 15 out 55 sampled residents (Residents # 2,4,5,6,7,8,9,10,11,12,13,14,15,17). There were several incidences of violence between residents, and several elopements which lead to resident hospitalization.

Findings included:

1) On at 2:41 PM Staff E stated "If we notice a resident is missing we have to call the police in 24 hours and report they are not in the ALF. We do rounds before we end our shifts. The residents go out as they please, they are mostly independent. We try to supervise them and make sure they are okay."

On at 2:45 PM, Staff H stated that he works in 3:00 pm to 11:00 pm and 3:00 pm to 7:00 am shifts and also works on Sundays from 11:00 pm to 7:00 am. He stated that the night shifts have one staff member.

On at 5:30 p.m. the Administrator stated that the facility was short of staff and said that she would increase the staff. She also stated that called the police every time she though the situation could be out of control.

A review of a calls-to-service report from the police department showed that Resident # 2 was missing and the police were called on , , , , , , , , , , and .

A review of Resident #2's file showed the resident was admitted on . Resident #2's health assessment dated revealed the following medical history and diagnoses: , Hx of ETOH (ethly, or drinking) . or Behavioral status: Oriented pleasant, calm, , slight paranoia. Nursing/treatment/ service requirements: Monthly follow up, medication management weekly, twice/weekly face to face, case management, , service as needed. The health assessment revealed the resident was not an elopement risk. The resident was

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independent with all activities of daily living (ADLs). The resident needed assistance with self-administration of medications.

On at 10:55 am Staff B stated, "Resident #2 used to go out and stay out overnight telling that he was going to work. We did not know what job he was he going to. His case manager told us he used to stay out of the other facility he came from for long periods of time, and that's why they discharged him. Most of the time they called the police and then he returned back by himself. His case manager and his doctor were informed every time and we call the police when he went out for more than 24 hours."

The facility did not have any documentation showing that adequate interventions were taken to prevent Resident #2 from leaving.

2) A review of police report of calls showed Resident#3 eloped on .

A review of Resident #3's file showed the resident was admitted on . A health assessment dated the following medical history and diagnoses: , . Physical and Sensory limitations: No. or behavioral status: Psych . Nursing/treatment/ , service requirements: N/A. The health assessment reveled the resident was not an elopement risk. The resident was independent with all ADLs. The resident needed assistance with self-administration of medications. Resident #3 was ultimately found by the police after four days missing, and was hospitalized in , 2017.

3) A review of Resident #4's file showed the resident was admitted on . The jail diversion program screening form showed the resident had a , diagnosis.

A review of police report of calls showed Resident #4 eloped on . The facility did not have any documentation of interventions related to the elopement.

4) Police report review showed Resident #5 was involved in a violent incident on .

A review of Resident #5's filed showed the resident was admitted on . Resident #5's health assessment dated revealed the resident was diagnosed with from , , , . Physical and sensory limitations: None. or behavioral status: , . The resident is independent with ambulation, needs supervision with bathing, dressing, eating, is independent with self-care ( ), toileting, and transferring. The health assessment revealed the resident is not elopement risk. The resident needed assistance with self-administration of medications.

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The facility did not have any documentation of interventions related to the incident.

5) A review of police report of calls showed Resident #6 eloped on .

A review of Resident #6's file showed the resident was admitted on . A health assessment dated had the following medical history and diagnoses: , , . Physical or sensory limitations: None. or behavioral status: Patient is , , calm. The health assessment revealed the resident was not an elopement risk. The resident is independent with all ADLs. The resident needed assistance with self-administration of medications. The facility did not have any documentation of interventions related to the elopement.

6) A review of the police report about calls from the facility showed Resident #7 was involved in violent incidents on and .

A review of Resident #7's file showed the resident was admitted on . Resident #7's health assessment dated revealed the following medical history and diagnoses: (, , Chronic Type). Physical or sensory limitations: None. or behavioral status: . The health assessment revealed the resident was not an elopement risk. The resident is independent with ambulation, bathing, and dressing, needs supervision with eating, self-care ( ), is independent with toileting and transferring. The resident needed assistance with self-administration of medications. The facility did not have any documentation of interventions related to the violent incidents.

7) A review of police report of calls showed Resident #8 eloped on .

A review of Resident #8's file showed the resident was admitted on . Resident #8's health assessment dated revealed the following medical history and diagnoses: , type II, OA, . Physical or sensory limitations: None. or behavioral status: , , , . The health assessment revealed the resident was not an elopement risk. The resident is independent with ambulation, needs supervision with bathing, dressing, eating, self-care ( ), and is independent with toileting and transferring. The resident needed assistance with self-administration of medications. The facility did not have any documentation of interventions related to the elopement.

8) Review of the police report about calls from the facility showed Resident #9 was involved in a violent incident on .

A review of Resident #9's file showed the resident was admitted on . Resident #9's health

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assessment dated revealed the following medical history and diagnoses: , Tobacco user, . Physical or sensory limitations: None. or behavioral status: . Nursing/treatment/ , , service requirements: N/A. The resident is independent with all ADLs. The resident needs assistance with self-administration of medications. The facility did not have any documentation of interventions related to the incident.

9) Review of the police report about calls showed Resident #10 was involved in a violent incident on .

A review of Resident #10's file showed the resident was admitted on . Resident #10's health assessment dated revealed the following medical history and diagnoses: , , and . Physical or sensory limitations: None. or behavioral status: Awake, alert, oriented x 3. Nursing/treatment/ , , services requirements: Supervision. The resident needed supervision with all ADLs. The facility did not have any documentation of interventions related to the incident.

10) Review of the Police report about calls showed Resident #11 was involved in a violent incident on .

A review of Resident #11's file showed the resident was admitted on . Resident #11's health assessment dated revealed the following medical history and diagnoses: , . Physical or sensory limitations: None. or behavioral status: . The resident is independent with ADLs. The health assessment revealed the resident was not an elopement risk. The resident needs assistance with self-administration of medications. The facility did not have any documentation of interventions related to the elopement.

11) Review of the police report about calls showed Resident #12 was involved in a violent incident on .

A review of Resident #12's file showed the resident admitted on . Resident #12's health assessment dated revealed the following medical history and diagnoses: Acute , or behavioral status: Acute , . The resident is independent with all ADLs. The resident needs assistance with self-administration of medications. The facility did not have any documentation of interventions related to the incident.

12) Review of the Police report about calls from the facility showed Resident #13 was involved in a violent incident on .

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A review of Resident #13's file showed the resident was admitted on . Resident #13's health assessment dated revealed the following medical history and diagnoses: , type, /, type II , tremors, murmur, and . Physical or sensory limitations: no limitations so far. or behavioral status: low level. Nursing/treatment/ , service requirements: Resident #13 needs therapies sessions, follow up and medication management implemented by ALF and observe any changes in behavior. The resident is independent with all ADLs and needs assistance with self-administration of medications. The facility did not have any documentation of interventions related to the incident.

13) Review of the police report showed Resident #14 was involved in a violent incident on .

A review of Resident #14's file showed the resident was admitted on , Health assessment dated showed diagnosis of , . The resident is independent with ambulation, bathing, dressing, supervision with eating, is independent with self-care ( ), toileting, and transferring. The resident needs assistance with self-administration of medications. Per health assessment the resident is not an elopement risk. There was no documentation of interventions related to the incident.

14) Review of the police report about calls from the facility showed Resident #15 was involved in a violent incident on .

A review of Resident #15's file showed the resident was admitted on . Resident #15's health assessment dated revealed the following diagnoses: , , , type (provisional) R/O Major . or behavioral status: mildly improved memory and concentration but oriented in all spheres. Nursing/treatment/ , service requirements: monitoring of medication administration. The resident is independent with all ADLs and needs assistance with self-administration of medications. The facility did not have any documentation of interventions related to the incident.

15) Review of the police report about calls from the facility showed Resident #17 was involved in a violent incident on .

A review of Resident #17's file showed the resident was admitted on . Resident #17's health assessment dated revealed the following medical history and diagnoses: , . or behavioral status: Paranoia. Nursing/treatment/ , services requirements: PRN (as needed). The resident is independent with ambulation, needs supervision with bathing, eating and is

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independent with dressing, self-care ( ), toileting, transferring. The resident needed assistance with self-administration of medications. The facility did not have any documentation of interventions related to the incident.

CLASS II

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

Based on record review and interview the facility failed to accurately assess residents at risk for elopement, and failed to implement adequate responses or safety measures for 5 out 53 sampled residents (Residents # 2, 4,6, 8 and 11).

Findings included:

A review of the resident records showed that there was no documentation that the facility reassessed Residents #2, #4, #6, #8 or #11 after the elopements. The health assessments stated residents were not under elopement risk. There was no documentation that the residents carried their identification, place of living, or address when out of the facility.

A review of facility records showed that there was no documentation that elopement policies and procedures were reviewed or updated, or that thee staff was retrained.

There was no documentation that the facility submitted 1 day or 15 day adverse incident reports to the state regarding any elopement.

On at 2:23 PM Staff C stated "I have been working here for 14 years, I mostly do the cleaning. If I notice that any of them are missing we have 24 hours to call the police and let the Administrator know. We do rounds when we get here, and before we leave and we have a shift change."

On at 2:36 PM Staff D stated "I have been working here for 11 years, we have been trained in case a resident is missing. The first thing would be that if we notice the resident is missing for more than 24 hours we have to call the police and notify the administrator. Right away we would start the search process, Administrator will go look for them. We do round before every shift change to know who is here. The residents here are independent and they come and go as they please. We have an 11:00 PM curfew."

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On at 2:41 PM Staff E stated, "I have been working here for 1 year, if we notice a resident is missing we have to call the police in 24 hours and report they are not in the ALF. We do rounds before we end our shifts. The residents go out as they please, they are mostly independent. We try to supervise them and make sure they are okay."

On at 2:45 PM, Staff H stated that he works in 3:00 pm to 11:00 pm and 3:00 pm to 7:00 am shifts and also works on Sundays from 11:00 pm to 7:00 am. He stated that on the night shifts, he worked alone.

On .2017 at 2:45 PM, Staff H Stated "We have a board in the office where they mark residents that are in the facility. We have a notebook where we write about the resident's behavior. Staff stated that at 11 PM they close the fence doors. Residents that do not sleep in the facility, we call family and inform and after 24 hours we call the police. When in the office have the door open to see any resident approach the front door to go into the facility. In that case I open the door. Every half an hour we make rounds, go to the 2nd floor to see residents are sleeping, also observe those who are sitting on the patio. When someone did not come to sleep or did not come to take dinner, I call the family. If the resident has no family I call the social worker, and after 24 hours, call the police and make the missing report. I inform the police how the resident was dressed, etc. "

On at 5:30 p.m. the Administrator said that the facility was short of staff and that she will increase the staff.

A review of police calls to the facility for elopements from through showed:

1) Resident #2 eloped from the facility on the following dates: , , , , , , , , , , , . On , the resident was found by the police and was hospitalized.

A review of Resident #2's file showed the resident was admitted on . Resident #2's health assessment dated revealed the following medical history and diagnoses: , , Hx of ETOH . or Behavioral status: Oriented pleasant, calm, , , slight paranoia.

On at 10:55 am Staff B stated Resident #2 used to go out from facility and stay out overnight telling that he was going to work. She stated did not know what job he was going. She said "His case manager and his Doctor were informed every time and we call the police when he went out for more than 24 hours." She stated that most of the time they called the police, he returned back by himself. She stated that Resident #2's case manager told her he used to stay out of the other facility he came from for

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a long periods of time.

2) Resident #4 eloped from the facility on .

A review of jail diversion program screening form for Resident #4 showed the resident was diagnosed with , . The facility did not have a completed health assessment or an elopement risk assessment for Resident #4.

3) Resident #6 eloped from the facility on .

A review of Resident #6's file showed the resident was admitted on . Resident #6's health assessment dated revealed the following medical history and diagnoses: , , . Physical or sensory limitations: None. The health assessment revealed the resident was not an elopement risk. The resident is independent with all ADLs. The resident needs assistance with self-administration of medications. The facility did not have any documentation of an elopement risk assessment.

4) Resident #8 eloped from the facility on .

A review of Resident #8's file showed the resident was admitted on . Resident #8's health assessment dated revealed the following medical history and diagnoses: , type II, OA, . Physical or sensory limitations: None. or behavioral status: , , . The health assessment revealed the resident was not an elopement risk. The resident is independent with ambulation, needs supervision with bathing, dressing, eating, self-care ( ), and is independent with toileting and transferring. The resident needs assistance with self-administration of medications. The facility did not have any documentation of an elopement risk assessment.

5) Resident #11 eloped from the facility on .

A review of Resident #11's file showed the resident was admitted on . Resident #11's health assessment dated revealed the following medical history and diagnoses: , . Physical or sensory limitations: None. or behavioral status: . The resident is independent with ADLs. The health assessment revealed the resident is not an elopement risk. The resident needs assistance with self-administration of medications. Resident #6 eloped from the facility on .

A review of Resident #6's file showed the resident was admitted on . Resident #6's health assessment dated revealed the following medical history and diagnoses: ,

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. Physical or sensory limitations: None. The health assessment revealed the resident was not an elopement risk. The resident is independent with all ADLs. The resident needs assistance with self-administration of medications. The facility did not have any documentation of an elopement risk assessment.

Class II

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on record review and interview the facility failed to have medications locked at all times.

Findings included:

On at 11:15 a.m., observed the refrigerator in the medication unlocked. The lock handle was loose from the refrigerator wall. Inside was a bottle of glargine injection and a box containing Lantus 100 units/ml. The bottle had no name on it and the lantus belonged to a discharged resident.

On at 11:15 a.m. the Administrator stated that she had not seen the lock handle was broken and that she would fix it immediately.

Class III

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

Based on record review and interview the facility failed to have adequate staffing to meet scheduled and unscheduled needs for the entire census of 52 residents (Residents #1-52). The facility experienced multiple elopements and incidences of violence between residents, 61 of 88 of which occurred during evening, night and weekend shifts between and , 2017.

Findings included:

Cross reference: A25 and A32

A review of police calls to service for the facility between and , 2017 showed that there

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were 88 contacts with law enforcement. Of those, 61 incidents occurred during evening, night and weekend shifts and 53 involved violence, missing residents and/or hospitalizations.

A review of the staffing schedule showed that 10 people worked at the facility. Of those 10, one was the cook, one was the housekeeper, There was only one staff member on duty on evenings and weekends.

On at 2:45 p.m. Staff H stated that he works in 3:00 pm to 11:00 pm and 3:00 pm to 7:00 am shifts and also works on Sundays from 11:00 pm to 7:00 am. He stated that the night shifts are covered by only one staff, which was him. He further stated that at dinner time, he assisted the staff in charge of the kitchen, and that she was the only one that worked with him until her shift ended at 6:30 p.m.

On at 5:30 PM, the Administrator agreed that the facility was short of staff.

Class II

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 and failed to ensure that equipment and appurtenances were maintained in good working order.

Findings included:

On between 8:50 AM and 3:30 pm, observed the following conditions:

- in the second floor of the building, between and 28, the floor and tube next to toilet was rusted.
- had no nightstands
- had no shower curtain in the
-Unit 2 had no door, a black substance resembling mold or mildew on the ceiling, patchy paint and broken blinds.
-Unit 1 had an armoire with a missing door.
- had a dirty floor. There was no space between resident beds. There was only one nightstand in the , which housed three residents.
- had a broken dresser, which contained only two drawers and was missing the third drawer.
- had no closet for the two residents living in the .
- had no closet. The missing a wall tile. The a foul odor.
- had a foul odor. There was no closet for the 2 residents living in the .

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- had a shower tile missing.
- had broken tile in the shower.
- had a foul odor, and contained a litter box. Observed a cat in the . The Administrator stated that she did not have documentation of immunizations for the cat.
- had no closet, and staff did not have a key to the .
- had a foul odor.
- had a missing dresser drawer.
- had broken blinds, and emergency water was stored in the residents' closet area.
- , which housed two residents, had only one dresser and one nightstand.

-Dining kitchen- observed a cat in the back yard with cat food on the ground. The Administrator stated that she didn't have any documentation of immunizations for the cat.

On at 9:00 AM the Administrator stated she would make repairs.

Class III

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

Based on record record review and interview the facility failed to submit the one day and fifteen day adverse incident reports for 6 out of 53 residents who eloped (Residents #2,3,4,6,8 and 11). the facility also failed to complete and submit one or fifteen day adverse incident reports for _______ occurrences of violence between residents which required police intervention

Findings:

A review of Police report of calls made from the facility for elopements from through showed:

Resident #2 eloped on , , , , , , , , , , .
Resident #8 eloped
Resident #4 eloped on
Resident #6 eloped on
Resident #11 eloped on
Resident #3 eloped on .

A review of the Adverse Incident Report System showed that the facility did not submit the one day or 15 day incident reports for the elopements.

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On at 5:30 p.m. the Administrator stated she did not report those elopements because those residents used to go out and come back to facility. She stated that most of the time residents arrived back at the facility after the police were called.

Class III