STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910716	11/28/2017
NAME OF PROVIDER OR SUPPLIER **NORTH LAKE RETIREMENT HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **1222 NORTH 16TH AVENUE HOLLYWOOD, FL 33020**	

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR# 2017006953, 2017011929 and 2017007074, was conducted on at Northlake Retirement Home Inc., License # 7375. The facility had deficiencies at the time of the investigation.

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

Based on interview and record review, the facility failed to ensure that a resident with an elopement history was identified as elopement risk resident and appropriate supervision provided to the resident for 1 out of 3 sampled residents (Resident #2). The facility also failed to notify appropriate parties of Resident #2's elopement.

The findings included:

On at 10:00 AM, an interview was conducted with the facility Administrator and the Assistant Administrator. The parties confirmed the elopement of Resident #2. The Administrator stated that at the time all of the required agencies and persons were notified of the elopement. The Assistant confirmed this statement.

A review of Resident #2's file revealed a demographic sheet with emergency contact information. Further review revealed a Health Assessment dated with a documented diagnosis of , and . The 1823 form also documents or behavioral status is alert and oriented. The form does not document he is an elopement risk. Although, the resident has a prior history. The resident's ADLs documented as follows; independent with ambulation, eating, tilting and transferring, requires supervision with dressing. He requires assistance with bathing and self-care .

A review of the local police report confirmed the elopement of Resident #2 on .

A review of the progress notes dated 11/ documented the following. The Resident was seen by Staff members; sitting at the dining for lunch. Resident had coffee and water. He was seen getting up from the table. He was overheard saying the air conditioning was too . He stood up to leave. The Staff was in the dining lunch and observed the Resident was missing. The Resident was identified as an elopement. The staff searched the entire facility. The nearby neighborhood was searched. The Resident was not found. The local Police department and the State Advocacy Agency was notified. No further details.

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On at 10:17 AM, a telephone interview was conducted with the Power of Attorney for Resident # 2. She stated on , the police came to her home between 6:30 PM - 7:00 PM. She stated they told her that her Grandfather was missing. She says the facility never called her and notified her of this event. She says the Resident had eloped twice before this incident. She says those two times they did notify her. She says her Father previously eloped and ended up in Miami at the hospital about 15 miles away. She stated she moved him to another facility because he had and the facility was not taking care of him.

A review of the One Day immediate Agency for Health Care Administration notification, (AHCA), dated , states Resident # 2 was seen in the dining water and coffee. He was overheard saying he was cod. The Staff later returned to the dining found the Resident missing. They searched the entire facility and the nearby neighborhood The notification report notes the physician was called, but it does not identify the name and the phone number of the Physician. The notification indicates the Emergency Contact was notified; but there was no mention of the name and the contact information of the Emergency Contact. The progress notes do not include any mention of notifications to the Physician and Emergency Contact. The 15-Day AHCA follow-up notification was not completed. The immediate one day AHCA notification was made by the Assistant Administrator, but he failed to complete the 15 day follow-up notification indicating the details of the outcome of the elopement and the facility corrective action to prevent further incidents of elopement

On at 03:00 PM, an Exit Conference was conducted with the Administrator. He stated the facility did did contact the daughter. However, the facility had no documentation to indicate the notification was completed, as required.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observations, interviews and record reviews, the facility failed to serve adequate amounts of palatable, nutritious meals with a variety of foods for all current residents residing at the facility (census 108).

The findings included:

On at 12:30 PM, an observation of the 4-week cycle menu posted on the wall indicated Soup, Pizza, salad and sliced pears were to be served for the meal on noted date. Observations revealed the Cook substituted the salad for carrots and corn as The meal was unappealing. The Pizza was soggy and contained excess sauce. There were several Residents eating ham sandwiches. The

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bread was observed dry and stale.

During numerous confidential interviews conducted on between the hours of 10 AM and 4 PM, revealed that the residents are not happy with the meal provided by the facility . They also expressed their displeasure with the quality, repetition, portion sizes and overall attractiveness of the food.

On at 01:30 PM, an interview was conducted with the Food Service Cook. She says she does have fish on the menu this week for dinner scheduled Tuesday and Friday, but they are two different types of fish. She says they do have sandwiches as alternatives daily.

The Administrator nor the Cook were able to provide any documentation indicating that they had met with residents regarding the menu or the food related concerns.

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 complete an adverse incident report (Full Adverse incident report) within 15 days to the Agency as required, for 1 out of 3 sampled residents (Resident #2). As evidence, of the facility failure to submit a full incident report for Resident #2's elopement which jeopardized his safety due to his current diatgnosi and status.

The findings included:

A review of the facility's incident report revealed Resident #2 eloped from the faciltiy on . Further interview and record review revealed the resident had eloped on prior occassions. Review of the resident 's Health Assessment dated with a documented diagnosis of and .

A review of the local police report confirmed the elopement of Resident #2 on .

A review of the One Day immediate Agency for Health Care Administration notification, (AHCA), dated , states Resident # 2 was seen in the dining water and coffee. He was overheard saying he was cod. The Staff later returned to the dining found the Resident

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