STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911401	**08/21/2018**
NAME OF PROVIDER OR SUPPLIER **SANTA BARBARA HOME I**	STREET ADDRESS, CITY, STATE, ZIP CODE **3319 SW 24 TERRACE** **MIAMI, FL 33145**	

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

0000 - Initial Comments

A Complaint (CCR #20180110327) survey was conducted on . . . . . and concluded . . . . . . Santa Barbara Home I with Limited Mental Health (LMH) had the following deficiencies identified at the time of the survey:

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

Based on record review and interview the facility failed to identify and assess 1 out of 11 (Resident #1) samples residents who was at risk for elopement. The facility also failed to develop an elopement preventive plan.

Findings as follow:

Record review revealed Resident #1's assessment date . . . . . showed diagnoses of , unspecified without behavioral disturbance. Resident #1 was identified as an elopement risk

Facility observation notes revealed, "Resident #1 ran away when none of the staff was in the area. The police was notified and they wrote a police report with a case number. The legal guardian was notified. We called the hospitals. He wasn't there." Police report documentation showed the facility filed a missing person report for Resident #1 on .

The facility's elopement and resident evaluation policy placed in resident's record stated, "Establish a method of assessing necessity of wandering and eloping at the time of admission as needed. Develop and implement preventive measures to make sure to stop wandering and eloping whenever possible."

The facility failed to assess Resident #1 who was identified as an elopement risk. The facility also failed to develop a plan to prevent residents' elopement in an Assisted Living Facility.

On . . . . at 3:00 PM Staff C stated that he was working on . . . . . when Resident #1 eloped. He did not find resident so he called 911 and the Administrator, who called the guardian.

On at 3:10 PM Staff C stated that knew that Resident #1 could elope because he had exhibit that behavior in another Assisted Living Facility he lived at. He stated for that reason they had closed supervision on him. He said Resident #1 had never exhibited an elopement behavior in this Assisted Living Facility.

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SUMMARY STATEMENT OF DEFICIENCIES
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On [redacted] at 3:20 PM Staff D stated Resident #1 eloped from facility on [redacted], jumping the facility's 6 feet fence. She stated that facility called the police and reported the incident to AHCA. The facility also reported the incident to his guardian. She stated Resident #1 had never eloped before. She stated resident had Limited Mental Health problems.

On [redacted] at 3:40 PM Staff B stated Resident #1 used to walk a lot in the facility but never showed an elopement behavior.

[redacted] at 10:30 PM Staff E stated that on [redacted] was preparing to assist residents with self-administration of medications when Resident #1 eloped. He stated the fence was locked, he believed he jumped the fence in the facility's right side. He stated that neither Resident #1 or other residents had showed an elopement behavior. He stated that they called the 911 and the Administrator.

On [redacted] at 5:00 PM during the exit Staff D stated that facility staff had closed supervision over Resident #1 but it is not possible to have one to one supervision because this is an Assisted Living Facility and there are no one staff for each resident.

Class III

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

Based on observation, record review and interview the facility failed to have a staffing schedule showing the minimum staffing hours per week.

Findings as follow:

On [redacted] at 3:00 PM Staff B and C were observed in the facility with 11 residents.

The staffing schedule posted showed Staff F was scheduled to work from 6 PM to 6 AM and Staff G was off. There were no other staff scheduled to work on other shifts. The facility failed to have a minimum of 212 staffing hours per week documented.

On [redacted] at 5:20 PM the facility owner (Staff D) stated Staff G and F did not work in facility anymore and she added, they knew the schedule was wrong because she had problems with the computer when it was printed.

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Class III

0081 - Training - Staff In-Service - 58A-5.0191(2-3) FAC

Based on observation, record review, and interview the facility failed to ensure that staff received control, sanitation and universal precautions training for 1 out of 8 sampled staff (Staff H).

Findings as follow:

On at 9:00 AM Staff H was observed in the kitchen cooking.

Record review showed the facility did not have a completed record for Staff H which included control training.

On at 11:00 AM the Assistant Administrator stated the facility did not have records for Staff H because she was in training. Staff H had been working for about 4 or 5 days.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on observation, record review, and interview the facility failed to have 1 out of 8 (Staff H) sampled staff records containing a copy of the employment application with references.

Findings as follow:

On at 9:00 AM Staff H was observed in the kitchen cooking.

Record review showed the facility did not have a completed record for Staff H which included control training.

On at 11:00 AM the Assistant Administrator stated the facility did not have records for Staff H because she was in training. Staff H had been working for about 4 or 5 days.

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0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview the facility failed to have an updated health assessment for 1 out of 10 (Resident #7) facility residents. The facility discontinued the use of Resident #7's vest without having a Doctor's order.

Findings as follow:

Review of Resident #7's health assessment dated showed the resident had a diagnosis of . . . . . The assessment revealed Resident #7 has . . . . life vest which he needs to worn.

On . . . . . at 1:45 PM Resident #7's guardian stated, that around 6 months ago Resident #7 was discontinued the vest use because he remains stable with his prescribed medications.

at 5:36 PM Staff B stated Resident #7 was not using the life vest but she had no the order to discontinue its use. She stated that because the guardian is involved in resident's doctor's appointments, sometimes, it is difficult to have all the update orders for him.

Class III

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Findings as follow:

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Facility observation notes revealed, "Resident #1 ran away when none of the staff was in the area. The police was notified and they wrote a police report with a case number. The legal guardian was notified. We called the hospitals. He wasn't there." Police report documentation showed the facility filed a missing person report for Resident #1 on .

The facility's elopement and resident evaluation policy placed in resident's record stated, "Establish a method of assessing necessity of wandering and eloping at the time of admission as needed. Develop and implement preventive measures to make sure to stop wandering and eloping whenever possible."

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Class III

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Findings as follow:

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The staffing schedule posted showed Staff F was scheduled to work from 6 PM to 6 AM and Staff G was off. There were no other staff scheduled to work on other shifts. The facility failed to have a minimum of 212 staffing hours per week documented.

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0081 - Training - Staff In-Service - 58A-5.0191(2-3) FAC

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Findings as follow:

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Record review showed the facility did not have a completed record for Staff H which included control training.

On at 11:00 AM the Assistant Administrator stated the facility did not have records for Staff H because she was in training. Staff H had been working for about 4 or 5 days.

Class III

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Based on observation, record review, and interview the facility failed to have 1 out of 8 (Staff H) sampled staff records containing a copy of the employment application with references.

Findings as follow:

On at 9:00 AM Staff H was observed in the kitchen cooking.

Record review showed the facility did not have a completed record for Staff H which included control training.

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Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on observation, record review, and interview the facility failed to conduct the level 2 background screening for 1 out of 8 sampled staff (Staff H).

Findings as follow:

On at 9:00 AM Staff H was observe in the kitchen cooking alone.

Record review showed the facility did not have an eligible level 2 background screening for Staff H.

On at 11:00 AM the Assistant Administrator stated the facility had not conducted a level 2 background screening for Staff H because she was in training but working for about 4 or 5 days.

Unclassified