STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911829	**09/17/2018**
NAME OF PROVIDER OR SUPPLIER **CENTRAL PALACE RESIDENTIAL,**	STREET ADDRESS, CITY, STATE, ZIP CODE **4491 SW 8 STREET** **MIAMI, FL 33134**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on , 2018. Central Palace Residential (license #7107) with Limited Nursing Services and Limited Mental Health components had 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 adequate supervision by not knowing the whereabouts of two out of five sampled residents, (Residents #1 and #2). Resident # 1 was found and by the police in another state. Resident # 2 was found by the policeafter leaving the facility, and was hospitalized.

Findings included:

1) Review of an record from the state of New York received on showed that Resident #1 was there on for trying to access the transit system without paying his fare.

Review of the facility's record for Resident #1 revealed that on at 6:30 PM the resident was seen by Resident #5 with a suitcase, taking a taxi. Resident #5 reported this to the Administrator, and on the facility started looking for Resident #1 by calling the hospitals. At 6:30 PM after not finding Resident #1 they made a police report. A progress note dated stated that Resident #1 was discharged from the facility even though his being missing was reported to the police.

Review of Resident #1's health assessment dated , 2017 showed diagnoses of and , . Physical or sensory limitations: none. or behavioral status: recently discharged from state hospital. The resident was not identified as an elopement risk. The resident was independent with activities of daily living. Further review revealed the last evacuation & assessment tool dated , 2017 showed that the resident did not have a diagnosis of 's and had never verbalized any intent prior to wandering or elopement, however on the facility's progress note stated that they had spoken with Resident #1 and told him that every time that he left and came back to the facility, he needed to tell them. There was no further documentation of intervention regarding the resident's leaving the facility without staff knowing his whereabouts.

Review of the facility log in/out book showed: , Resident #1 left the facility at 9:40 AM to go to a local supermarket and came back at 10:30 AM. At 6:30 PM, the resident left again and never returned.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911829	**09/17/2018**
NAME OF PROVIDER OR SUPPLIER **CENTRAL PALACE RESIDENTIAL,**	STREET ADDRESS, CITY, STATE, ZIP CODE **4491 SW 8 STREET** **MIAMI, FL 33134**	

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

On , 2018 at 2:35 PM, the Assistant Administrator stated, "When I went to the local supermarket, an employee told me that Resident #1 told her that he had the money to go to New York. On a detective from the police department called and told us that the New York police had found the resident and wanted to know if the resident had an warrant so they could close the case."

On , 2018 at 1:10 PM, Staff C stated, "Resident #1's friend is my ex-husband. He was best friends with Resident #1. He is the one who said that the resident had $150 and was going to New York with the family."

On , 2018 at 1:32 PM, Resident #1's friend stated on the phone, "One day, the resident asked me about a bus for New York and I mentioned one bus line but I did not know how to get there with public transportation. Resident # 1 told me that was thinking about leaving to New York. The resident was and I told the resident not to leave the facility; that he was under very good care at the facility."

2) Review of the record of Resident #2 revealed the she had left the facility on , 2018 at 5:30 pm for a walk and that she was not present at dinner time or at the medication time. The facility notified Resident #2's case manager and filed a police report on . The last health assessment completed on stated the resident had diagnoses of , , , 2 and ; was independent with her activities of daily living and had no elopement risk. There was no documentation of other elopement assessment.

On at 3:15 PM the assistant manager stated on the phone that Resident # 2 had been found by the police and taken to a hospital on .

Review of the hospital records showed Resident # 2 had been placed under by the police on at a fast food restaurant due to bizarre behavior. The record stated that the resident's clothes were covered in her own fecal matter. The resident had on her feet. She'd stated that she could not remember where she lived. She'd stated that she had not taken her medicine for a while. Resident #2 was hospitalized for eight days.

Class II

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

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911829	**09/17/2018**
NAME OF PROVIDER OR SUPPLIER **CENTRAL PALACE RESIDENTIAL,**	STREET ADDRESS, CITY, STATE, ZIP CODE **4491 SW 8 STREET** **MIAMI, FL 33134**	

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

Based on record review and interview, the facility failed to obtain an updated assessment for risk of elopement for two of five residents who showed signs of elopement risk (Residents 1 and 3) .

Findings included:

1)

A review of the facility's elopement policy and procedures showed, "Administrator, licensed practitioner nurse or licensed nurse will:

Assess resident for further elopement risk.
Implement elopement risk interventions.
Provide direction to caregiving staff via Incident Report and/or resident's service plan.

Record review of Resident 1's last health assessment dated , 2017 showed a diagnoses of or sensory limitations: type. Special precautions: None. Independent with ambulation, bathing, dressing, eating, , toileting and transferring. Health assessment dated , 2018 showed no elopement risk.

Record review of Resident 1's last Evacuation & Assessment tools dated , 2017 showed that the resident did not have a diagnosis of 's and has never verbalize any intent prior to wandering or elopement.

Record review of Resident 1's progress notes showed:

- "The resident is better; the facility spoke to the resident that every time the resident leaves and comes back to the center needs to communicate it, even though we are supervising".

Facility record review of Log in/out book showed: showed Resident 1 left the facility at 9:40 AM to go to a local grocery store and came back at 10:30 AM. At 6:30 PM, the resident left again the facility and was found a month later in New York.

2)

Resident record review for Resident 3 showed the last health assessment was dated .
Diagnoses were and chronic pain. The resident was independent with

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911829	09/17/2018
NAME OF PROVIDER OR SUPPLIER **CENTRAL PALACE RESIDENTIAL,**	STREET ADDRESS, CITY, STATE, ZIP CODE **4491 SW 8 STREET MIAMI, FL 33134**	

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

ambulation, dressing, eating, [illegible], toileting and transferring. He needed supervision with bathing, and was maked as having no elopement risk.

A review of Resident 3's progress notes showed:

[illegible], "The resident left at 3:30 pm with $20 that his father requested to give him".

On [illegible], 2018 at 9:05 AM, Resident 3 stated, "Sometimes I let them know that I am leaving and sometimes I don't. I keep forgetting to tell them. They tell me to let them know that I am leaving".

Class III

0052 - Medication - Assistance with Self-Admin - 429.256(3-4); 58A-5.0185 (3)

Based on observation and interview the facility failed to follow the correct procedure outlined by the state when assisting with self-administration of medications 2 out of 16 sampled residents (# 14 and # 15).

Findings included:

On at 12:20 PM Staff D was observed punching the medications out of the cards for Resident # 14 into her hands and putting the tablets in the hand of Resident # 14 . Staff D then handed a cup of water to the resident.

On at 12:23 PM, observed Staff D, without washing or gloving her hands, assist Resident # 15 with her medications. Staff D punched the medication out of the card into her hand and them put the medication in Resident # 15's hand with her own hand.

On at 12:40 PM Administrator stated, "Is because Staff D only gives medications on Mondays."

Class III

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

Based on observation and interview Facility failed to ensure that medications are kept locked at all times.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911829	**09/17/2018**
NAME OF PROVIDER OR SUPPLIER **CENTRAL PALACE RESIDENTIAL,**	STREET ADDRESS, CITY, STATE, ZIP CODE **4491 SW 8 STREET** **MIAMI, FL 33134**	

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

Findings included:

On at 9:15 AM observed in # a bottle of on top of the dresser. # was share by Resident # 16 and another resident.

On at 9:15 AM Staff C stated, "It is Resident # 16's ."

On at 9:16 AM Resident # 16 stated, "Why I cannot keep it?"

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview Facility failed to provide a safe living environment free of hazards and to ensure that all existing architectural, and structural systems, and appurtenances are maintained in good working order.

Findings included:

On at 9:05 AM observed in # the curtain was broken.
On at 9:05 AM Resident # 8 stated, "My cat did it."
On at 2:30 PM Administrator stated, "It happens every week. I replace that Curtain every week because her cat breaks it."

On at 9:23 AM observed in # the door was missing one of the locks and the hole where the lock belonged had a plastic bag stuck inside.
On at 9:23 AM Staff C stated, "Maintenance was given the money to buy the lock and he is going to put it today."

On at 9:35 AM observed in # the door was opened and the lock was broken.
On at 9:35 AM Staff C stated, "Yes they broke the door."

On at 11:05 AM observed broken toilets in the backyard.
On at 11:05 AM Administrator stated, "the city comes to pick them up once a week and we cannot place them on the streets."

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911829	**09/17/2018**
NAME OF PROVIDER OR SUPPLIER **CENTRAL PALACE RESIDENTIAL,**	STREET ADDRESS, CITY, STATE, ZIP CODE **4491 SW 8 STREET** **MIAMI, FL 33134**	

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

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview, the facility failed to maintain an accurate staff roster the employment status in the Background Screening Clearinghouse.

Findings included:

Review of the facility's roster in the Background Screening Clearinghouse in the morning on revealed that Staff K and L were listed as active staff . At noon on they had and end date of and respectively and update date of . The Owner and Staff J were not listed.

On , the Administrator stated at 10:25 AM, "I did not know Owner needed to be on the roster." At 12:22 PM the Administrator stated, "Staff J works the nights. I will put him."

Unclassified