STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967918	**12/05/2018**
NAME OF PROVIDER OR SUPPLIER **HOME AWAY FROM HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **324 LYMAN PL WEST PALM BEACH, FL 33409**	

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

0000 - Initial Comments

An unannounced licensure compliant survey, CCR #2018015255, that was commenced on and concluded on at Home Away From Home, License #11913. The facility 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, it was determined the facility failed to maintain and/or update a resident's record regarding any significant changes regarding illness, hospitalization, third party services, etc., for 1 out of 3 sampled residents' files reviewed (Resident #1).

The Findings include:

During confidential record reviews, it was determined that Resident #1 had been admitted to the hospital on various occassions for extended periods of time on or around , for an . Further record review revealed the last hospital admission resulted in a stay for over a month. Upon discharge from the hospital as part of the discharge planning, it was noted the hospital contacted the Administrator to discuss the return of Resident #1 to the ALF. The hospital notified the Administrator (date unknown) that the resident was stable and could safely return to the ALF (to his home). However, the Administrator failed to contact the hospital and/or set up a visit for evaluation of the resident to return to the ALF. The Administrator never made any attempts to cooperate with the hospital for the resident to return the resident to the ALF .

On at 9:20AM, an interview with the Administrator revealed Resident#1 lived at the facility for 10 years and he has a history of and Failure and he receives . Since his admission to the facility he has been in and out of the hospital. The resident was sent to the hospital and returned to the facility with a ( ) line for IVantibiotics. While at the facility (date unknown) the resident pulled out the line and he went to the hospital for reinsertion of and returned to the facility. Upon return to the facility, the resident pulled out the line a second time, and had to be sent to the hospital (No dates were provided by the Administrator). The Administrator stated, she believed the resident was declining because he usually does not behave this way and she does not believe he knew what he was doing when he was pulling out the lines.

Record review of Resident#1's file and medical examination dated revealed the resident suffered from , , , , ll (Non-), Failure,

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( ) and disoriented at times. However, further review of the file including observation notes failed to documentation and/or illustrate a timeline of events (including signficant health changes) that led up to the facility's decision to not accept Resident #1 upon discharge from the hospital. Further review revealed no documentation of any hospital admissions or returns, no documentation of significant changes related to Line, and the need for third party services. The facility had no documentation of the resident's medical progress since residing at the facility. The file also lacked evidence of a 45 day discharge notice to the resident and/or legal guardian illustrating the reason the facility decided to terminate the residency contract.

During further interview with the Administrator on 11/27/2018 at approximately 11:30 AM, aforementioned was discussed. The Administrator was asked if she had any documentation or information to illustrate how the facility determined the resident was no longer appropriate for continued residency and/or met the criteria for immediate discharge (without a 45 day discharge notice). The Administrator also confirmed that she had not made contact with the hospital regarding the discharge of the resident, the stabilization of the resident's condition and the care needs required for the resident. Therefore, the facility was unable to illustrate that the resident no longer met the criteria for continued residency and/or an immediate discharge was warranted.

During a interview the Administrator on 11/27/2018 at approximately 12:00PM, she acknowledged the findings and provided no additional documentation for review.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on record review and interview, it was determined that the facility failed to honor a resident's rights, for 1 out of 3 sampled records reviewed (Resident #1). As evidence of the facility failure to provide a 45 day written termination notice to Resident #1 and immediately discharging a resident from the facility while in the hospital without notice.

The findings include:

During confidential record reviews, it was determined that Resident #1 had been admitted to the hospital on various occassions for extended periods of time on or around , for an . Further record review revealed the last hospital admission resulted in a stay for over a month. Upon discharge from the hospital as part of the discharge planning, it was noted the hospital contacted the Administrator to discuss the return of Resident #1 to the ALF around . The hospital

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notified the Administrator (date unknown) that the resident was stable and could safely return to the ALF (to his home). However, the Administrator failed to contact the hospital and/or set up a visit for evaluation of the resident to return to the ALF. The Administrator never made any attempts to cooperate with the hospital for the resident to return the resident to the ALF .

Record review of Resident#1's file and medical examination dated revealed the resident suffered from II (Non-), Failure, ( ) and disoriented at times. However, further review of the file including observation notes failed to documentation and/or illustrate a timeline of events (including signficant health changes) that led up to the facility's decision to not accept Resident #1 upon discharge from the hospital. Further review revealed no documentation of any hospital admissions or returns, no documentation of significant changes related to Line, and the need for third party services. The facility had no documentation of the resident's medical progress since residing at the facility. The file also lacked evidence of a 45 day discharge notice to the resident and/or legal guardian illustrating the reason the facility decided to terminate the residency contract.

Review of Resident #'1's executed contract revealed the facility was entitled to give the resident a 45 day written discharge notice upon the facility intent to terminate the resident's contract. During an interview with the Administrator on 11/27/18 at 11 AM, she confirmed that the facility adheres to the 45 day discharge policy (as per regulation). However, the facility was unable to provide proof of the 45 day discharge notice.

During further interview with the Administrator on 11/27/2018 at approximately 11:30 AM, aforementioned was discussed. The Administrator was asked if she had any documentation or information to illustrate how the facility determined the resident was no longer appropriate for continued residency and/or met the criteria for immediate discharge (without a 45 day discharge notice). The Administrator also confirmed that she had not made contact with the hospital regarding the discharge of the resident, the stabilization of the resident's condition and the care needs required for the resident. Therefore, the facility was unable to illustrate that the resident no longer met the criteria for continued residency and/or an immediate discharge was warranted.

During a interview the Administrator on 11/27/2018 at approximately 12:00PM, she acknowledged the findings and provided no additional documentation for review.

Class III