STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911829	R 12/18/2018
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 Second Revisit Survey was conducted on . . . . . 6, 2018 through . . . . . 18, 2018. Central Palace Residential, with Limited Nursing Services and Limited Mental Health components license number 7107, had the following deficiencies identified at the time of the survey:

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

Based on observation, record review and interview, the facility failed to provide at least 45-days notice of relocation or termination of residency from the facility to three of eight sampled residents (Resident 1 and 7). The facility gave verbal notices of termination of contract without reasons for relocation set in writing. In addition, the facility failed to maintain control methods, as a stray cat was allowed to roam in the food preparation area.

Findings Included:

1) Resident 1 was found by the police after she eloped from the facility; the police took her to a local hospital. This was the second time that this incident happened. The facility agreed to discharge the resident and send her to another facility without any documentation from the hospital or giving the resident a 45-days notice of termination of contract.

On , at 9:20 AM, the Administrator, stated, "The doctor told me that it was better if she was transferred to the facility that she will be going because of the area, that sometimes they need to change environment."

Review of the resident's progress notes dated showed the resident discharged. "We spoke to the case manager; he called the Administrator of the other ALF who will accept her."

Review of Resident 7's record showed a Health Assessment completed on .

On , at 9:22 AM, the Administrator stated the psychiatrist visited resident and conducted an involuntary examination and sent resident to the hospital on by ambulance.

The Administrator stated resident returned from the hospital on and on she was discharged to home with her sister.

Review of the resident's progress notes showed on that the Administrator contacted the

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resident 'sister and informed her that the facility no longer wanted the resident to remain at the facility and would be discharging her. The sister picked up resident on . A 45-day notice was not given to the resident.

2)
On , at around 7:55 AM a stray cat was observed inside the kitchen.

On , at around 12:43 PM Staff B stated that the kitchen door was open and that the cat came from the outside. The Administrator stated that the facility had the cat problem before and she had spoken to the staff to make sure the cat did not get inside the kitchen.

Class III

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

Based on record review and interview, the facility failed to follow it's elopement policy and procedures when one of nine sampled residents (Resident 1) eloped for a second time from the facility on

Findings included:

Review of Resident 1's record showed an admission , a photo of the resident as she was elopement risk, progress notes that revealed that the resident left the facility for a walk carrying her identification on and did not come to the facility. According to the Administrator, the identification contained the resident's name, day of birth, facility name, address, phone number and direct phone number of the administrator. The facility found the resident in a local hospital on . According to the progress notes, the local police found the resident worried and and that she voluntarily entered the hospital. The resident was and not taking medications for a period of at least nine days. The facility did not change their policy to avoid this from happening again as the resident had previously eloped on .

The last health assessment from the facility, completed on stated that the resident had diagnoses of , 2 (Less severe), and ; she was independent with her activities of daily living, no special precautions of or other conditions and was on risk of elopement. There was documentation of elopement assessment risk conducted on with a 7 or higher score, which means that the resident was on high risk of elopement.

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Review of the hospital records showed the resident was hospitalized under by local police on as she was walking on and off the major highway and not complying with officer. "Observed by passers-by and officers to be walking voluntarily in and our vehicular traffic on major highway. Failed to obey police and comply by walking on sidewalk. She requested to be since she is a danger to herself. Requested to be taken to a local hospital." Chief complaint of , abnormal values present on vital signs with a diagnosis of type and . Resident 1 was discharged from the hospital with a diagnosis of multiple episode, currently acute episode.

Review of Resident 1's record revealed the she had also left the facility on 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 , , , II and ; was independent with her activities of daily living and had no elopement risk. There was no documentation of other elopement assessment.

Review of the hospital records showed Resident 1 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 . 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 1 was hospitalized for eight days.

On , at 9:08 AM during a phone call interview, the Resident 1's case manager stated that the resident stayed at the hospital for evaluation due to the second episode that she had as she had eloped in the past and that the doctors wanted her to be stable. The resident was transferred directly from the hospital to another assisted living facility because the current facility did not want the resident . The hospital and the social worker contacted the case manager and informed him that they found another facility for her.

Review of the facility's elopement policy and procedures showed the facility must contact 911, police within 1 hour of identified missing resident, however the card given by the police with a case number showed that the report was made a day after the elopement, on . The policy further showed tat the facility must initiate an incident report with the agency online reporting within 24 hours, however the report was initiated , 3 days after the incident. The policy showed that the facility must investigate the incident to determine the cause or contributing factors, however there was no documentation of an investigation.

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On , at 9:20 AM, the Administrator stated, "The doctor told me that it was better if she was transferred to the facility that she will be going because of the area; that sometimes they need to change environment. We have done things to avoid this from happening again; we sat down and talked to her, we put a lock at the gate now, they need to ring to get out and enter the facility. What else can we do? Go with her to the store; that will violate the resident rights."

On , at 11:20 AM, the Administrator stated on a phone interview, "We implemented as a plan of correction the ring at the door; now we can see 100% who is coming in and out of the facility. I was there that day and I spoke to her before leaving to make sure that she understood that she needed to come ; we would talk to her every time. She was alert; she was going to the store."The administrator further stated that the action that the facility took was to speak to the resident on different occasions in reference to leaving and coming to the facility. In , the facility implemented a system on the entrance/exit door, where anyone entering or exiting the facility needed to ring so the staff at the office will open the door after watching on a camera screen and documenting the resident's names on a log. This system would only give the facility control of who was coming in or going out.

Uncorrected
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 free of hazards and failed to maintain appurtenances in good repair.

Findings Included:

On , at 7:30 AM, observed in the floor cracked from the bathroom to the entrance door of the room. Resident 9 stated that she reported the cracked floor to management some time ago but that the facility had not done anything about it. At 12:43 PM, Staff B stated that Resident 2 complained about many things but she did not know about the cracked floor. In addition, the Administrator stated that she was not aware the floor had a crack.

On , at 7:55 AM had a strong cigarette smoke odor. One of the residents had been smoking cigarettes in the room. At around 12:43 PM the Administrator and Staff B stated that this was not the first time the resident was caught smoking in the room and that they have told her to stop.

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Uncorrected
Class III