STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968947	01/18/2019
NAME OF PROVIDER OR SUPPLIER **A SENIOR LIVING DREAM LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **13442 SW 284TH ST** **HOMESTEAD, FL 33033**	

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

0000 - Initial Comments

A complaint investigation (CCR#2018017467) survey on and concluded on . A Senior Living Dream Llc, with limited mental health component, had the following deficiencies identified at the time of the survey:

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, interview and record review, the facility failed to maintain an updated written record for three out of six sampled residents (# 2, #1 and #4). Resident #2 with injury that resulted in hospitalization. Resident #1 eloped from the facility and there was no updated written record about it. Resident #4 went to the hospital.

Findings included:

1. On at 10:17 AM, observed Resident #2 sitting in a wheelchair with five staples in his , .

On at 10:17 AM, Resident #2 stated he had a when going to the bathroom in the middle of the night, around 4 AM. He did not recall date that it happened but it was the end of . The resident did not call for help for going to the bathroom. He and hit his but he noticed the when touch it. Staff B probably heard the noise and came to help him. The facility called the emergency services and the resident was sent to the hospital.

Ambulance record for Resident #2 that the ambulance transported him on for status post with to top of the , with controlled . Review of Resident #2's hospital record showed a assessment of a 5 cm , .

Review of Resident #2's facility record showed that there were no notes about the injury or hospitalization.

On at 12:42 PM, Staff B stated that Resident #2 attempted to get out of the bed and lost the balance and hit his . The facility called rescue and he was taken to the hospital. She stated it happened before the end of year in the middle of the night, and that she heard a noise and when to check and found out he . He was from the .

2. Review of Resident #1's record showed that the admission date was on . There was a print out of the adverse incident, generated on showing that the resident eloped at 7:07

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PM.

Review of Resident #1's health assessment (AHCA form 1823) completed on . He had a medical history and diagnoses of and and was mild intellectual . The resident was identified as an elopement risk who was independent for all activities of daily living (ambulation, bathing, , eating, self-care, toileting and transferring).

Review of Resident #1's police record showed that the resident missing date was . The facility's administrator reported to the police officer that the resident walked to the store to buy a soda and never returned. Later he added that the resident suffered from and and was familiar with the area.

On at 12:37 PM, Staff B revealed that Resident #1 was in the facility for short period of time. He used to go out for buying cigarettes and coke. It was just one time that he did not returned, and on that day when it was time that the resident was supposed to be and he did not, she called the administrator and reported it.

3. Review of Resident #4's record showed that the admission date was on . Health assessment (AHCA form 1823) completed on . It showed the medical history and diagnoses of , AMS ( ), , acute failure, , , type 2 , , , , , protein-calorie . The resident was alert, , followed commands. The resident was identified with precautions and as an elopement risk. The resident was independent for ambulation, eating, and transferring but needed supervision with bathing, , self-care, and toileting. The facility did not update the written record after Resident #4 went to the hospital from to . There was a discharge after care plan in the resident's record from the hospital. The reason for admission to the hospital was , restless, and , . The discharge diagnosis was unspecified , not due to a substance or known physiological condition. There was no documentation of the hospitalization in the facility's notes.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(I)

Based on record review and interview, the facility failed to include as part of its resident elopement response policies and procedures that the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name. The facility failed to follow their elopement policies and procedures for one out of six sampled residents (#1). The facility

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failed to have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary for one out of six sampled residents (#4).

Findings included:

1. Review of facility's elopement and procedures showed that any resident diagnosed with 's or which has the potential for elopement would have a current picture in their file that the facility can give to the police authorities and use for identification purpose. The facility will also give the resident's family or guardian or responsibility party the information on the 's Association with the intention to suggest the purchase of an ID bracelet for the resident. Any elopement attempt or actual elopement will be documented in resident's file and copies of the 1-day and 15 days Adverse Incident Report would be kept on file. It further said that at a minimum, the facility would have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The photo identification would be made available for the file within 10 calendar days of admission. In the event a resident is assessed at risk for elopement subsequent to admission, photo identification would be made available for the file within 10 calendar days after a determination is made that the resident is at risk for elopement. The photo identification could be taken by the facility or the resident's family/caregiver.

2. Review of Resident #1's record showed that the admission date was on . There was a print out of the adverse incident report, generated on showing that the resident eloped at 7:07 PM. There were no notes about the elopement aside from the incident report.

Review of Resident #1's health assessment (AHCA form 1823) completed on showed the resident had a medical history and diagnoses of , and , , , and was mild intellectual . The resident was identified as an elopement risk who was independent for all activities of daily living (ambulation, bathing, , eating, self-care, toileting and transferring).

Review of Resident #1's police record showed that the resident missing date was . The facility's administrator reported to the police officer that the resident walked to the store to buy a soda and never returned. Later he added that the resident suffered from , and , and was familiar with the area.

On at 12:37 PM, Staff B revealed that Resident #1 was in the facility for short period of time. He used to go out for buying cigarettes and coke. When it was time that the resident was supposed to be and he was not, she called the administrator and reported it.

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3. Review of Resident #4's record showed that the admission date was on . Health assessment (AHCA form 1823) completed on . It showed the medical history and diagnoses of , AMS ( ), , acute , failure, , type 2 , protein-calorie . The resident was alert, , followed commands. The resident was identified with precautions and as an elopement risk. The resident was independent for ambulation, eating, and transferring but needed supervision with bathing, , self-care, and toileting. There was no picture for the resident in the record.

On at 2:02 PM, the administrator revealed that Resident #4 did not have identification with him.

Class III

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

Based on observation, record review, and interview, the facility failed to maintain a written work schedule which accurately reflected its staffing pattern for a given time period. The facility work schedule was not readily available to residents or their representatives.

Findings included:

Facility record review showed no daily work schedule of the direct care staff was posted or readily available.

On at 2:16 PM, the Administrator stated he acknowledged that the staff schedule was not available.

Class III

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

Based on record review and interview the facility failed to ensure one out of three sampled Staff had documentation of the required staff in-service training (Staff C).

Findings Included:

Review of Staff C's files showed her hired date was . There was no documentation of the employee having received at least two hours of pre-service orientation prior to interacting with residents.

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There was no documentation of three hours of in-service training on resident behavior and needs/providing assistance with daily living or training regarding the facility's resident elopement response policies and procedures within 30 days of employment.

On at 2:16 PM, the Administrator stated he was not able find the training certificate(s). He stated if Staff C required the in-services- training's he would provide the training's. He also stated this is the first time he heard of the in-service trainings.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(&) FS; 58A-5.0241 FAC

Based on observation, interview and record review, the facility failed to submit an adverse incident report within one business day after the incident to AHCA for one out of six hundred sampled residents (Resident #2).

Findings included:

1. On at 10:17 AM, Resident #2 sat in the wheelchair with five staples on the .

On at 10:17 AM, Resident #2 stated he had a when got out for going to the bathroom in the middle of the night, around 4 AM. He did not recall date that it happened but it was by the end of . The resident did not call for help for going to the bathroom. He and hit his but he noticed the when touch it. Staff B probably listened the noise and came to help him. The facility called the emergency services and he was transferred to the hospital. On at 12:42 PM, Staff B revealed that Resident #4 attempted to get out of the bed and lost the balance and hit his . The facility called rescue and he was taken to the hospital. It happened before the end of year in the middle of the night. She listened to a noise and when to check and found out he . He was from the . The resident refused to go the hospital but she and the administrator talked to him about that he needed to go to the hospital for checking. She thought that he went to the closer hospital. Ambulance record for Resident #2 that the ambulance transferred him on for status post with to top of the controlled . The resident on the way to restroom and had to top of .

Review of Resident #2's hospital record showed that he went to the hospital on at 8:17 AM with a injury due to a . The happened at 6 AM while he got out of wheelchair, tipped forward and could not brace himself in time. assessment showed that he sustained a 5 cm ,

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and the was repaired with five staples. The resident was discharged on at 9:57 AM.

Review of Adverse Incident Report System showed no documentation of a report made about the incident within one business day.

On at 1:22 PM, the Administrator revealed that Resident #4 between 5 AM and 5:30 AM, he did not know if the resident went out of the facility and returned. He said that this was the reason that he did not file an adverse incident report.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and interview, the facility failed to have a copy of its approved Comprehensive Emergency Management Plan (CEMP).

Findings Included:

Record review showed no documentation of the facility's approved CEMP.

On at 1:41 PM, the administrator stated he was not able to find the CEMP approval letter and stated that he would check on the website. At 1:45 PM, he added that he was not able to find the CEMP approval letter and once he found it, he would fax it to the Agency for Health Care Administration office.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation, record review, and interview, the facility failed to develop and implement written policies and procedures to ensure that it can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The facility also failed to notify each resident and the resident's legal representative in writing about its Emergency Power Plan (EPP). In addition, the facility did not have a copy of its approved emergency power plan letter.

Findings Included:

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A review of the facility's record on . . . . . showed no documentation of an approved Emergency Power Plan and written EPP policies and procedures that were readily available for a review. The facility did not have a detailed plan to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power. The facility did not have documentation to show that residents or their legal representatives was informed in writing of the implementation of the emergency power plan.

On at 2:16 PM, the administrator stated he did not have fuel onsite at the facility. He stated he was not aware residents or legal representative were to be giving a written letter explaining the facility Emergency Power Plan. He also stated he has the Emergency Power Plan approval letter but unable to locate it at the time.

Class III