STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966938	03/12/2019
NAME OF PROVIDER OR SUPPLIER **BETSY'S LOVING HOME, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **309 SW 68TH AVENUE** **PEMBROKE PINES, FL 33023**	

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR #2019003504 was conducted on at Betsy's Loving Home, Inc, License 11079. The facility had deficiencies at the time of the survey.

0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to ensure that 1 out of 4 sampled residents (resident #1) received a medical examination by a physician or a physician extender within 30 days before placement in the facility.

The findings are:

Review of Resident's #1's record indicated that he was admitted to the facility as a temporary emergency placement by the (State Agency) on . Review of the resident's court order dated on indicated that the resident shall be placed in a facility that must meet the resident's needs and the resident shall receive a medical examination to determine the amount and type of care commensurate with the resident's desires, needs and means. Further review of this resident's record indicated that there was no medical examination form for review of the resident's assessment for the appropriateness of placement in the facility.

In an interview with Resident #1's physician on at 10:10am, he stated that he was familiar with the resident's medical care and that he examined the resident on or about and that he was not requested by anyone to examine the resident before the resident was admitted to the facility. He stated that the resident was diagnosed with a previous and , and had exit-seeking behaviors. He stated that the resident was functional, was able to ambulate independently and was an elopement risk due to his limitations. He stated that he received no requests from anyone to receive the outcome of this resident's medical examination.

In an interview with the administrator on at 10:25am, she stated that Resident #1 did not have any medical examination or health assessment forms for review in his record. She stated that she did not ensure that the resident received a medical examination within 30 days before placement in the facility to determine the appropriateness of placement in the facility.

In an interview with the Administrator on at 10:45am, she stated that she admitted Resident #1 to the facility on without contacting the resident's physician to ascertain the resident's appropriateness of placement in the facility. She stated that she arranged for the resident to visit his

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physician on or about and she did not follow-up with the physician's office to retrieve the physician's outcome of the resident's medical examination.

In an interview with {name of agency} on at 6:30pm, she stated that Resident #1 did not receive a medical examination for the purpose to determine his appropriateness of placement in the facility before his admission to the facility on . She stated that the administrator did not request for the resident to be examined or assessed by a physician before the resident was admitted to the facility.

Class III

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

Based on record review and interview, the facility failed to implement the Agency's resident elopement standards and the facility's written policies and procedures to identify, prevent and respond to resident elopements for 2 out of 4 sampled residents (residents #1 and 4).

The findings are:

Review of resident's #1's record indicated that he was admitted to the facility as a temporary emergency placement by the {name of agency} on . Review of this resident's record indicated that there was no medical examination form for review of the resident's elopement risk status. Further review of the resident's record indicated that there was no identifying photograph of the resident in this record.

Review of the facility's resident elopement policies and procedures, titled "wondering risk scale" indicated that the facility administrator must assess each resident prior to or upon admission to determine their risk by using the risk scale form. Review of the facility's risk scale form indicated that the facility must assess each resident's mental status, mobility and speech patterns, history of and diagnosis to determine a numerical risk score equivalent to one of the following: low risk, at risk to and at high risk to . Review of the facility's resident elopement policies and procedures, titled "protocol of care" indicated that all the facility residents shall be assessed for elopement risk upon admission or when a resident experiences a significant change in condition. Review of the facility's resident elopement policies and procedures indicated that all the facility staff members must receive resident specific elopement training to identify, prevent and respond to resident elopements.

In an interview with caregiver A on at 8:15am, she stated that she wasn't sure what to do if and when a facility resident eloped or went missing from the facility. She stated that since she was hired one

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day ago, she was not properly trained in resident elopement standards.

In an interview with the administrator on at 8:35am, she stated that Resident #1 eloped from the facility on at approximately 8:30am. She stated that she departed the facility on at approximately 7:30am and that caregiver C called her by telephone on at around 8:30am to report that resident #1 left the facility without her knowledge. She stated that she immediately came to the facility on at approximately 10:00am to begin searching for resident #1. She stated that she first searched around the neighborhood and she received a call from the resident's daughter on at around 10:30am to inform her that resident #1 was seen walking in the street in Miami Beach by a friend. She stated that the resident traveling to Miami Beach, which was about 40 minutes away by motor vehicle from the facility, was credible because this was were the resident used to live and work.

In an interview with the Administrator on at 10:45am, she stated that she had to get a photograph of Resident #1 from the resident's daughter on because she did not have this resident's identifying photograph in the resident's record. She stated that although it was likely that the resident had his wallet with money in it, she was not sure if the resident had his personal identification or the facility's identification on his person before he eloped from the facility on .

Review of Resident #4's health assessment dated on , it indicated that the resident was diagnosed with and , and he was an elopement risk. Further review of the resident's record indicated that there was no identifying photograph of the resident in this record.

In an interview with the Administrator on at 11:45am, she stated that Caregiver C did not previously receive facility-specific resident elopement training when she was left alone with the residents in the facility on and that Caregiver A also did not complete this training when she was hired and started working in the facility on . She stated that before Resident #1 was admitted on , she went to the resident's daughter's home to evaluate the resident and she was informed by the daughter that the resident had exit-seeking behaviors. She stated that she did not perform a resident risk assessment upon admission of any of the facility residents, including residents #1 and 4.

In an interview with resident #1's daughter on at 4:10 PM, she stated that resident #1 had recently escaped her home about 5 or 6 times and that she informed the administrator of this when the administrator evaluated the resident on . She stated that she relied on the administrator's evaluation of the resident to properly place the resident and to be capable to meet his needs in the facility.

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In an interview with caregiver B on at 5:10 PM, she could not what her role was when the facility declared a resident elopement. She presented to not be able to understand English at this time. In an interview with the administrator on at 5:12 PM, she stated that caregiver B spoke Creole language primarily and it was difficult for her to understand the English language. In an observation at this time, the administrator asked caregiver B what her role was during a resident elopement and she stated that she was too nervous to explain the resident elopement process.

In an interview with the{name of agency} on at 6:30PM, she stated that reason why resident #1 was under the protective placement program before his admission to the facility, was due to the resident's recent and continuous attempts to leave his daughter's home. She stated that the resident resided with his daughter before moving into the facility. She stated that she understood that the administrator was aware of the resident's exit-seeking behaviors and she relied on the administrator's evaluation of the resident to properly place the resident and to be capable to meet his needs in the facility.

Class III

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

Based on record review and interview, the facility failed to include 2 out of 3 sampled employees (staff members A and C) in its background screening employee roster.

The findings are:

Review of the facility's background screening employee roster on indicated that Staff Members A and C were not listed as employees of the facility to have received background screenings.

In an interview with the Administrator on at 8:50 AM, she stated that Staff Members A and C were hired as Resident Caregivers on and respectively. She stated that she was not aware that Staff Members A and C were not presently listed in the facility's background screening employee roster.

Unclassified