STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910711	04/10/2019
NAME OF PROVIDER OR SUPPLIER **MIDTOWN MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **2001 POLK STREET** **HOLLYWOOD, FL 33020**	

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR #2019004380 and CCR #2019004470, was commenced on and conlcuded on at Midtown Manor, License #6508. The facility had deficiencies identified at the time of the survey.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on interview and record review, the facility failed to ensure that the Initial (completed upon admission) Health Assessment form (AHCA 1823 form) was accurate and complete in it's entirety; to ensure a resident met the criteria for admission and that the facility could provide the appropriate level of care and supervision, for 1 of 3 sampled resident records reviewed (Resident # 1).

The findings included:

On a review of the AHCA 1823 form dated was conducted. It was revealed the following sections were coded as "none identified"; Medical history and diagnosis, Physical or sensory limitation, or behavioral status, and Nursing/treatment/ service requirements. Also, the section regarding whether the resident is an elopement risk was marked "No".

A review of the medical chart for Resident # 1 reveals he suffers from . The medical chart also stated that he suffers from and Bi-Polar . However, these diagnosis were not documented on the AHCA 1823 form under the diagnosis section. Further review revealed he is considered a adult that requires assistance with self-administration of medications. The medical chart revealed physician orders to treat these diagnosis.

On at 09:30 AM, an interview was conducted with the facility Administrator. She stated the resident had been homeless for two years prior to his facility admission. She stated that the staff must remind the resident to provide self-care grooming and bathing practices. Although, the 1823 form indicates that he is independent with bathing and self care grooming. She stated that when the resident was admitted into the facility; he already had been assigned a court appointed Guardian. She says the Guardian advised her that the resident has a habit of leaving the facility for several days at a time. However, the resident was not coded as an elopement risk on the AHCA 1823 form. The 1823 form indicates the facility should observe the resident's whereabouts and well-being. As of the day of the survey, it was noted that the resident had been missing from the facility for a couple of days and had not returned.

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During a further interview with the Administrator on , it was revealed that the facility was unable to provide documentation indicating that the facility had appropriately assessed the resident to ensure that the facility was capable of meeting all of the care needs of the resident; including supervision due to a history of elopement/ . Also, the facility was unable to demonstrate any plans implemented to provide and oversee the resident's daily whereabouts. The facility, as part of the assessment process failed to appropriately assess/evaluate an elopement risk resident and properly identify this resident to facility staff; and to ensure appropriate identification remained on the resident at all times.

On at 04:00 PM, an interview was conducted with the Administrator. The Administrator acknowledged the findings. An additional interview with the Administrator on at 3:24 PM, revealed the resident was still missing and had not been located.

Class II

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

Based on interview and record review, the facility failed to follow their elopement policies and procedures, for 1 of 3 sampled resident records reviewed (Resident # 1). As evidence of the facility failure to provide appropriate supervision to a resident at risk for elopement resulting in the extended elopement of a resident (Resident#1).

The findings included:

A review of the facility elopement policy (no effective date noted) revealed the following steps to be completed by staff in the event of a resident elopement.

1. Check sign in sheet
2. Search entire facility
3. Call 911 and follow directives given by the authorities.
4. Contact the Administrator
5. Contact family members. Contact the doctor.
6. Complete the elopement form and place in the binder.

Review of confidential records revealed Resident #1 left the facility on and as of , hasn't returned to the facility. Further review revealed the facility had not contacted the next of

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kin/representative or law enforcement until . It was also noted the resident sufferes from .

During an interview on at 09:30 AM with the Administrator, the following was revealed to the surveyor. She stated on , Resident # 1 signed out of the facility and had not returned as of . She stated she contacted local Law Enforcement on and filed a missing persons report. She stated that she contacted the Resident's Guardian and she agreed that Law Enforcement should be contacted. She stated the resident had not ever left the facility for such a long period of time.

A review of the facility incident report was conducted. The report was dated at 3PM. The incident report shows the Resident has not been seen since afternoon. Made report with police at 3 PM .

A review of the medical chart for the Resident indicated that the Resident was admitted into the facility on . He suffers from , , , , Bi-polar , and . He is a adult that requires assistance with self administration of medication. He requires prompting with bathing and self-care grooming. Further review revealed the resident is receiving medication management for , , , , and Bi-polar .

On at 10 AM, a request was made to the Administrator to provide documentation/evidence of the elopement protocol and policy implemented regarding Resident # 1's elopement on . She confirmed that the facility did not have any documentation indicating any diligent efforts made to locate Resident #1. She stated that no family members were contacted because they are not really involved in his care. She also confirmed that she had not contacted Resident#1's Physician. She further stated that the Resident did not take his medications with him when he left the facility.

On at 02:26 PM, an interview was conducted with the Resident's Guardian. She stated when she admitted the Resident into the facility; she advised the Administrator that she wanted a restricted environment because he was an elopement risk. She stated she was informed that the facility could not restrict him from coming and going. She stated she has not heard from the Resident, nor has he returned to the facility as of today.

During a review of the facility census records, it was noted that Resident #1 was listed as "Can Not Leave Facility". During an interview with the Administrator, at this time; the coding for Resident #1 was discussed. No additional information was provided regarding Resident #1. The Administrator was questioned regarding any other residents not allowed to leave the facility. She stated that Resident # 2

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and # 3 are not allowed to leave the facility because of their levels. She stated that they were at risk for harm if they were to leave unattended.

Class II

Refer to A 0007 for additional findings.

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

Based on interview and record review, the facility failed to submit the preliminary adverse incident report within 1 business day after the elopement incident took place and Law Enforcement was contacted, for 1 of 3 sampled resident records reviewed (Resident # 1).

The findings included:

Review of confidential records revealed Resident #1 left the facility on and as of , hasn't returned to the facility. Further review revealed the facility had not contacted the next of kin/representative or law enforcement until . It was also noted the resident sufferes from

During an interview on at 09:30 AM with the Administrator, the following was revealed to the surveyor. She stated on , Resident # 1 signed out of the facility and had not returned as of . She stated she contacted local Law Enforcement on and filed a missing persons report. She stated that she contacted the Resident's Guardian and she agreed that Law Enforcement should be contacted. She stated the resident had not ever left the facility for such a long period of time.

A review of the facility incident report was conducted. The report was dated at 3PM. The incident report shows the Resident has not been seen since afternoon. Made report with police at 3 PM . However, the facility had not filed an adverse report as required.

A review of Resident #1's file revealed the resident suffers from , Bi-polar , and . He is a adult that requires assistance with self administration of medication. He requires prompting with bathing and self-care grooming. Further review revealed the

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resident is receiving medication management for [redacted] and Bi-polar [redacted].
Resident #1's elopement places the resident at risk of harm and injury.

On [redacted] at 4 PM, an interview was conducted with the Administrator. She acknowledged the findings. She indicated that she was going to complete an immediate adverse incident form, but did not have time to do so. An additional interview with the Administrator on [redacted] at 3:24 PM, revealed the resident was still missing and had not been located.

Class