

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

VILLA OF KINGS & QUEENS OF DELRAY BEACH

**13415 BARWICK RD
DELRAY BEACH, FL 33445**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced licensure complaint survey, #2019013702, was conducted on _____, and _____ at Villa of Kings & Queens of Delray Beach. The facility had deficiencies at the time of the survey.	A 000		
A 010 SS=D	429.26(1&9) FS; 58A-5.0181(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (9) A _____, ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a	A 010		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2019
NAME OF PROVIDER OR SUPPLIER VILLA OF KINGS & QUEENS OF DELRAY BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 13415 BARWICK RD DELRAY BEACH, FL 33445		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 1 physician who agrees that the physical needs of the resident are being met. 58A-5.0181 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a _____ medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a _____ may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A _____, ill resident who no longer meets the criteria for continued residency may continue	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VILLA OF KINGS & QUEENS OF DELRAY BEACH

**13415 BARWICK RD
DELRAY BEACH, FL 33445**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 2 to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to reassess a resident after the resident demonstrated significant behavior changes, in which the results	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VILLA OF KINGS & QUEENS OF DELRAY BEACH

**13415 BARWICK RD
DELRAY BEACH, FL 33445**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 3 are documented on a new Health Assessment form (AHCA 1823 form); to ensure the resident met the criteria for continued residency, for 1 of 3 sampled residents (Resident # 1). The findings included: On at 10:30 AM, an interview was conducted with the Administrator. She stated the resident consistently showed the behavior of exit-seeking since admission. She stated the staff constantly had to redirect him when he tried to leave the facility. She stated she was made aware that Resident # 1 had eloped from his home in the community prior to coming to this facility. She confirmed that she did not have a license for Limited Mental Health. She stated the Resident's family told her that the Resident did not have any medical insurance. Therefore, she had not obtained his history, psych evaluation or assessment and physical reports. On at 02:25 PM, an interview was conducted with Staff A and Staff B (staff directly involved with Resident #1's care). They both indicated that during the 9 months that the resident remained in the facility, he was an elopement risk and was always trying to get out of the facility. They both confirmed that they would have to ask him to return to his seat. Review of Resident #1's record revealed he was admitted to the facility approximately Resident #1's Health Assessment (AHCA form 1823) dated shows the resident's diagnosis as The form does not show resident having any physical/sensory, /behavioral status .	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2019
NAME OF PROVIDER OR SUPPLIER VILLA OF KINGS & QUEENS OF DELRAY BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 13415 BARWICK RD DELRAY BEACH, FL 33445		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 4 The form also notes that the resident is not an elopement risk, marked "no". Further review of the forms notes the resident is independent with all Activities of Daily Living (ADLs). The medication listed on the AHCA 1823 form indicates that Resident # 1 receives a month injection of . . . , Maintena of 300 mg. The Administrator failed to obtain the diagnosis for the medication offered. A review of the medical dictionary indicates that . . . , Maintena is used for . . . and Further review of Resident #1's file indicates the resident is taking However, no diagnosis or further documentation related to this medication located within the file. During an interview with the Administrator on 10:30 and at 10 AM , it was revealed that the facility had not had the resident reassessed due to the significant behavior changes (exit seeking). It was also confirmed that the resident since admission to the facility was exit seeking and had not ceased this activity. Ultimately, resulting in the resident eloping from the facility on and located by local law enforcement on Class III	A 010		
A 025 SS=G	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VILLA OF KINGS & QUEENS OF DELRAY BEACH

**13415 BARWICK RD
DELRAY BEACH, FL 33445**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 5 _____ or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such _____. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VILLA OF KINGS & QUEENS OF DELRAY BEACH

**13415 BARWICK RD
DELRAY BEACH, FL 33445**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 6 method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide appropriate supervision to a resident that was exit seeking, for 1 out of 3 sampled residents (Resident #1). The findings include: On _____, a review of confidential records was conducted. It was revealed that Resident # 1 eloped from the facility at approximately 6:30 PM in the evening on _____, out of the patio door of the facility. The resident was later located by law enforcement on _____ about approximately 4.5 miles from the facility in Delray Beach. Resident was admitted to the hospital for _____. Resident #1 had no personal identification on him. The temperatures were noted in Delray Beach as the following: _____ = 93 degrees, _____ = 85 degrees and _____ = 86 degrees. During a confidential interview, it was revealed the elopement of Resident #1 was witnessed. It was revealed that Resident #1 always paced the floor and tried to open the door to get out. On _____ at 10:30 AM, an interview was conducted with the Administrator. She stated the resident consistently showed the behavior of exit-seeking since admission. She stated the staff constantly had to redirect him when he tried to leave the facility. She stated she was made aware that Resident # 1 had eloped from his	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VILLA OF KINGS & QUEENS OF DELRAY BEACH

**13415 BARWICK RD
DELRAY BEACH, FL 33445**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 7 home in the community prior to coming to this facility. She confirmed that she did not have a license for Limited Mental Health. She stated the Resident's family told her that the Resident did not have any medical insurance. Therefore, she had not obtained his history, psych evaluation or assessment and physical reports. Further interview with the Administrator, at this time, revealed Staff B contacted her to let her know around 6:50 PM on She says the staff said Resident # 1 went to his room after dinner. She says they could not locate him after conducting her rounds. She searched the area inside. She said Resident #4 told her that he walked out. The Staff looked in the front area and could not find him. Also, documented in Resident #1's file progress notes indicating the Resident left the facility unattended on The family made aware. 911 was called, after several unsuccessful attempts to locate resident. On at 02:25 PM, an interview was conducted with Staff A and Staff B (staff directly involved with Resident #1's care). They both indicated that during the 9 months that the resident remained in the facility, he was an elopement risk and was always trying to get out of the facility. They both confirmed that they would have to ask him to return to his seat. Review of Resident #1's record revealed he was admitted to the facility approximately Resident #1's Health Assessment (AHCA form 1823) dated shows the resident's diagnosis as The form does not show resident having any physical/sensory, . . . /behavioral status . The form also notes that the resident is not an elopement risk, marked "no". Further review of	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VILLA OF KINGS & QUEENS OF DELRAY BEACH

**13415 BARWICK RD
DELRAY BEACH, FL 33445**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 8 the forms notes the resident is independent with all Activities of Daily Living (ADLs). Review of the facility's ALF incident report regarding Resident #1 revealed the following. The report lacked documentation indicating the description of the incident and circumstances under which the incident occurred (question was left blank). Date of incident noted as _____ at 6:30 PM. Hospital admission marked "yes" and under name "911" noted. It also indicates law enforcement "notify". However, no date or time is indicated. Steps taken to prevent recurrence was also left blank. The form was signed by the Administrator on _____ at 6:30 PM. The facility also provided another internal investigation form regarding Resident #1 for review. The completion date and the preparer is unknown. The form states an internal investigation revealed that on _____ at 6:30 PM, Staff B observed Resident#1 went to bed after he had eaten. At about 6:45 PM, staff checked on resident and discovered resident was missing from his room. Another resident informed staff that the resident had left through the _____ door. Administrator and Owner were notified around 6:53 PM. It also notes the resident returned to the facility on _____. The form also identified steps implemented by the facility upon return of Resident #1. The steps implemented were the following: staff to check on resident every hour, staff instructed to frequently check on Resident #1, elopement drill completed on _____, bed alarm installed on Resident#1's bed, motion detector alarms installed at _____ doors, alarms set to ring before the door is open and lock on screen door was replaced with a stronger lock.	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2019
NAME OF PROVIDER OR SUPPLIER VILLA OF KINGS & QUEENS OF DELRAY BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 13415 BARWICK RD DELRAY BEACH, FL 33445		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 9 Further review of confidential records for Resident #1 confirms the resident has a prior history of elopement from home and other healthcare facilities. However, the facility had not completed a through assessment to determine the additional supervision required for this resident due to his history of elopement. Neither, was the 1823 form properly documented to indicate he was an elopement risk which would have also prompted the staff to provide the additional supervision based on the resident's care needs. During a further interview with the Administrator on _____, it was revealed that the facility at the time of Resident #1's elopement did not have an alarm system to alert staff when a resident was leaving or when the door was opening. It was further revealed, that although, the resident was constantly exit seeking the facility was constantly keeping an _____ on the resident. However, the resident was able to exit the _____ door undetected by staff on _____.	A 025		
A 032 SS=G	Class II 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(i) Resident Care - Elopement Standards 58A-5.0182 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or	A 032		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VILLA OF KINGS & QUEENS OF DELRAY BEACH

**13415 BARWICK RD
DELRAY BEACH, FL 33445**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 032	Continued From page 10 a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 58A-5.0181(2) (a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, 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 and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 58A-5.0191(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement	A 032		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VILLA OF KINGS & QUEENS OF DELRAY BEACH

**13415 BARWICK RD
DELRAY BEACH, FL 33445**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 032	Continued From page 11 response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(l), F.S. 429.41(1)(a)3 & 3(l),FS 3. Resident elopement requirements.-Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures. (l) The establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills. Facilities shall document the drills. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to determine that an at-risk resident have identification on their persons that include their name and the facility's name address and telephone number, for 1 of 3 sampled resident's reviewed (Resident # 1). It was also determined	A 032		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VILLA OF KINGS & QUEENS OF DELRAY BEACH

**13415 BARWICK RD
DELRAY BEACH, FL 33445**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 032	Continued From page 12 that the facility failed to establish and implement an Elopement policy and procedure that meets the minimum elopement standards. The findings included: Review of the facility's policy entitled, Policy & Procedures: Facility Elopement/Missing Resident Drill, written on _____ (revised _____). States the definition of an elopement is when a resident leaves the facility's property beyond the perimeter of the parking lot or further and is missing for ___ hours or more, without the facility's knowledge and who have not verbally informed the facility of their plans for returning to the facility nor signed out a pass. The policy fails to illustrate the actual steps for facility staff to complete once a person has eloped (or identified as missing) from the facility, the person responsible for each action (elopement response policy) to locate the person and notification to appropriate persons. On _____, a review of confidential records was conducted. It was revealed that Resident # 1 eloped from the facility at approximately 6:30 PM in the evening on _____, out of the _____-patio door of the facility. The resident was later located by law enforcement on _____ about approximately 4.5 miles from the facility. Resident was admitted to the hospital for _____. Resident #1 had no personal identification on him. During interviews conducted with Staff A, B and the Administrator on _____, all confirmed that Resident #1 was exit seeking since admission. It was further revealed that the resident had to always be redirected. The facility confirmed although, the resident was exit seeking (an	A 032		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VILLA OF KINGS & QUEENS OF DELRAY BEACH

**13415 BARWICK RD
DELRAY BEACH, FL 33445**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 032	Continued From page 13 elopement risk) the facility had not properly identified the resident to include identification on the resident. See A 0010 and A 0025 for Additional Findings. Class II	A 032		