Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964990	A. BUILDING: _____ B. WING _____	11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD PARK OF HOLLYWOOD	5770 STIRLING ROAD HOLLYWOOD, FL 33021

(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 Relicensure, Focused Control and Generator Assessment survey was conducted on - at Emerald Park of Hollywood. The facility had deficiencies at the time of the survey.	A 000		
A 032 SS=D	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (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 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 59A-36.006(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 59A-36.011(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	A 032		

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A 032	Continued From page 1 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 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)(i), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that they met the Elopement Standards to conduct a minimum of two (2) Resident Elopement Drills annually for all Direct Care staff and Administrators. The Findings Include:	A 032		

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A 032	Continued From page 2 On , an unannounced Relicensure survey was conducted at the facility. During the survey at 10:04 AM, this Surveyor was provided and reviewed the facility's Elopement Drills contained in the facility's binder: Observation revealed the following drills. On at 2:10 PM, 5 staff participated in the drill who works the 7:00 AM- 3:00 PM shift participated in the drill. There were no staff who work the 3:00 PM - 11:00 PM and 11:00 PM - 7:00 AM shift participated. Review of the facility's staffing documentation, and the Background Screening Roster revealed that the facility had more 35 direct care staff listed at the time of the drill. On at 1:15 AM, five staff from the 11:00 PM - 7:00 AM shift participated in the drill. Further observation of the Elopement documentation provided revealed that no additional Elopement drills were conducted in the 2019 calendar year. Review of the facility's staffing documentation, and the Background Screening Roster revealed that the facility had more than 35 direct staff listed at the time of the drill. Additional observation of the Elopement binder revealed that no other Elopement drill was conducted before or after the elopement drill dated in the 2020 calendar year. On at 3:04 PM, this Surveyor requested any additional drills that may not have been in the binder. The Administrator stated there may have been additional drills and was provided an opportunity to provide them. They were not provided. On at 3:29 PM, the Survey team met	A 032		

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A 032	Continued From page 3 with the Administrator, Corporate Regional Nurse and Director of Operations to conduct the Exit Interview. The Administrator stated she has them and would have provided them. This Surveyor reminded her that at least two (2) request was made, and opportunity given for them to be provided and they were not. They stated they understood. Class III	A 032		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a	A 093		

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A 093	Continued From page 4 licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to	A 093		

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A 093	Continued From page 5 document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local	A 093		

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A 093	Continued From page 6 disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observations, record review and interviews, it was determined that the facility failed to maintain an approved menu with portion size noted, by a licensed or registered dietitian with documentation of a signature, registration or license number, and date of annual review. The findings included: Observation made during a tour of the facility on at 11:15 am, the menus were not visibly posted. The menu did not state portion size, and did not include, registration or license number, and date of annual review with documentation of a signature.Observation of documentation of another Licensed Dietician posted along with a Lunch/Dinner Alternatives menu, which was not visibly posted, documents the signature and License Number. The names did not match to the regular menu. This Licensed Dietician no longer employed in the facility. Observation of lunch meal served both in the dining room and delivered to the resident's room was made on at 12:00 noon and every resident received the same meal: chef salad and a roll. The meal did not follow the menu or the alternative, or substitute menu. The meal of chef salad was not noted on the menu prior to meal served and is of equal nutritive value. A request made on . . . . . at 12:00 PM and at 9:45 AM to the designated certified food manager to review the menu, which requires portion size noted by a licensed or registered nutritionist/dietician signature annually, date, and license number. The facility provided the menu	A 093		

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A 093	Continued From page 7 which was observed earlier. During an interview and tour of the kitchen and 3-day emergency food supply with the designated certified food manager on at 10:00 am, observation of the menu in the kitchen also doesn't state portion size. The 3-day emergency menu and list of food needed were written, signed, dated, with license number for a Nutritionist that no longer is employed with the facility. A request was made for the Nutritionist License that is on the menu that the facility is following. The facility is following a Dietary Management System Corporate wide. During the 2-day survey, it has been noted that many attempts were made to obtain the approved menu by the designated certified food manger. The facility was unable to provide the requested documents. During the exit conference, on at 3pm with the Administrator, Nurse Consultant, and Director of Operations, they stated that she has the menu with portion size, signed dated with license number in her office and will send it for review. Upon receipt of the menus sent on for review, the facility remains to fail at providing a 4-week approved menu with portion size noted by licensed or registered dietitian with documentation of a signature, registration or license number, and date of annual review. Class III	A 093		