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 _____	02/13/2023

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

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A 000	Initial Comments An unannounced Complaint (#2023002398) survey was conducted on [redacted] at Emerald Park of Hollywood. The facility had deficiencies related to and unrelated to the Complaint at the time of the survey.	A 000		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) 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 Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to have a system or protocol in place to identify residents who were at risk for elopement potentially affecting 27 of the 27 residents residing in the Memory Care Unit (MCU) of the facility. The findings included:	A 032		

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A 032	Continued From page 2 Review of an investigative report completed by the facility revealed Resident #1 was admitted to the Assisted Living Facility (ALF) on at approximately 4:00 PM after a hospital stay. In an interview conducted with the Administrator on . . . . . at 9:54 AM, she stated the family had come to the building to bring the resident some clothing. They went to his room and could not find him. She further stated the Marketer had called her around 6:27 PM to notify her Resident #1 had eloped so she came to the facility to assist in the search. Resident #1 was located by the local police on , 2 days after he eloped from the ALF. In a further interview conducted with the Administrator on at 9:58 AM, she stated the resident was admitted to the ALF side because he was not identified as an elopement risk. She stated had she known, he would have been placed in the MCU on the second floor. She further stated the intake was completed with the family by the Marketer and she received the Resident Health Assessment 1823 which she reviewed. She stated they ask families whether the prospective resident has ever eloped from another facility or home, and they were told by a family member the resident had walked away from the hospital one time and from home one time. Review of Resident #1's Resident Health Assessment 1823 dated , documented he was not an elopement risk. His diagnoses included , , and with aggressive behaviors. Further he was independent with all his activities of daily living. In a further interview conducted with the	A 032		

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A 032	Continued From page 3 Administrator on . . . . . at 10:10 AM, an inquiry was made if Resident #1 was wearing a pendant or bracelet or any facility identification to which she stated he was not because he was admitted to the ALF side of the facility. She further stated it was unclear how the resident exited the building as they have a receptionist at the front so he did not leave through the front doors. She stated the elopement occurred around 6:27 PM on . The Administrator further stated in an interview conducted on . . . . . at 10:37 AM, she placed Resident #1 in the MCU when he was returned on . . . . . and she will also be contacting Corporate to see if she can get arm bracelets for the residents in the MCU, confirming there was no process currently in place to identify residents who were at risk for elopement. On . . . . . at 11:16 AM, Resident #1 was observed in the MCU dining room where he was sitting awaiting the lunch meal. An interview was attempted at this time however the resident spoke Creole, but was able to state he is doing good, the food is good, and everything is alright. Resident #1, now residing in the MCU, was not observed to have any form of identification on him with his name, location of current residence or any other contact information. On at 3:36 PM, another attempt was made to interview Resident #1 via an interpreter, the Dietary Manager who spoke Creole. The resident when asked, stated he had gone no where then stated he had gone to his mother's house and gave an address in Haiti. Resident #1 stated he was okay however grew increasingly agitated when asked additional questions. Resident #1 was unable to provide any	A 032		

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A 032	Continued From page 4 information as to where he was for the 2 days he was missing. In an interview conducted with the Administrator on [redacted] at 3:25 PM, she stated all residents residing in the MCU are an elopement risk that is why they are in the MCU. A request was made for a list of residents who were identified as an elopement risk with photo identification to which the Administrator stated they do not have a list of who are at risk for elopement as they are in the MCU. An inquiry was made if the facility has conducted any elopement training with their staff since Resident #1's elopement on [redacted], to which the response was "No". On [redacted] the resident census in the MCU was 27 residents. Observations throughout the day on [redacted] of the residents residing in the MCU, revealed no resident was observed to have any form of identification on their person in the event of an unforeseen elopement from the MCU. On [redacted] the exit conference was conducted with the Administrator who was informed of and acknowledged the findings. Class III .	A 032		
A 056	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs	A 056		

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A 056	Continued From page 5 for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , . . . , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The	A 056		

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A 056	Continued From page 6	A 056		

facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record.
(e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable.
(f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.
(g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following:
1. Practitioner's name,
2. Resident's name,
3. Date dispensed,
4. Name and strength of the drug,
5. Directions for use; and,
6. Expiration date.
(h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written

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A 056	Continued From page 7 prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that of 1 of 1 residents reviewed for medication administration, received their medications as prescribed and ordered as evidenced by the facility failed to ensure that prescriptions for residents who require assistance with self-administration of medication or medication administration, that their Physician ordered prescriptions are ordered from the pharmacy and available on site in a timely manner. The findings included: Review of Resident #1's facility file and documents were reviewed revealing no evidence of a Medication Observation Record (MOR). A review of the Resident's facility file revealed a hospital report dated [redacted] at 12:23 PM documenting his discharge medications to include the following: [redacted] 5 MG (milligrams) used for high [redacted]; [redacted] 10 MG used for high [redacted]; [redacted] 10 MG used for [redacted]; [redacted] 12.5 MG used for high [redacted]; [redacted] used for high [redacted]; Mementine 10 MG used for [redacted]; [redacted] 0.5 MG used for [redacted]; and [redacted] 0.25 MG used for [redacted]. A review of the Resident #1's Resident Health Assessment 1823 dated documented	A 056		

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A 056	Continued From page 8 his diagnoses to include high [illegible] and with aggressive behaviors. Further he requires Assistance with Self-Administration of medications. In an interview conducted with the Administrator on [illegible] at 1:21 PM, a request was made for Resident #1 MORs. She stated she would provide them for review. In an interview conducted with the Administrator on at 3:24 PM, a second request was made for the Resident #1's MORs. She stated she had provided them. However, review of the documents provided did not reveal the presence of Resident #1's MORs. In interviews with the Administrator on at 2:59 PM and 3:24 PM, requests were made for Resident #1 MORs. She stated again she was going to provide them. On [illegible] at 4:05 PM Receptionist Staff C brought Resident #1's MORs. A review of the MORs revealed the resident's medications were ordered as follows: - , 0.5 MG; one tablet at bedtime. - [illegible] - , 0.5 MG; one tablet at 10:00 AM - [illegible] - 12.5 MG; take one tablet per day - [illegible] -Novas 5 MG; take 5 MG per day , [illegible] Review revealed Resident #1's MORs did not document Resident #1 had received his medications since returning to the facility after his elopement on . Further review	A 056		

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A 056	Continued From page 9 revealed no medications were given on the date of the survey conducted on . In an interview conducted with the Administrator on . . . . . at 4:38 PM, in reviewing Resident #1's MORs, she stated the "N" on the MOR indicates 'Not Here'. She confirmed Resident #1 does not have any medications on site as yet, and that they are in route. She stated it is a delivery issue and they should be here before she leaves the facility for the day. She further confirmed again Resident #1 has not had any medications since he returned on . . . . . as they needed a Prior Authorization through his insurance, and thus the delay. There was no further explanation of the facility process to ensure that when residents are admitted to the facility, they are provided with their Physician ordered medications in a timely manner. On . . . . . the exit conference was conducted with the Administrator who was informed of and acknowledged the findings. Class III	A 056		