

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968678	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/25/2023
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOME SWEET HOME

**1613 MONROE SHEFFIELD RD
CHIPLEY, FL 32428**

(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 A complaint investigation (complaint number 2023006525) was conducted at Home Sweet Home, LLC on . Deficiencies were identified at the time of the survey.	A 000		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the	A 160		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

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A 160	Continued From page 1 facility, the log must indicate the date of (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related, a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the	A 160		

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A 160	Continued From page 2 county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain an up-to-date admission and discharge log. The findings include: During a tour of the facility beginning at 10:40 AM on , Resident #3 was observed ambulating to the living room from his bedroom. He had a large in place to his left upper arm and multiple noted to both	A 160		

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A 160	Continued From page 3 The facility administrator stated he is a new resident and has only been at the facility for "about 2 weeks", and was admitted from the local hospital. On at 2:05 PM, the administrator was asked for the facility's Admission/Discharge Log. She produced the log approximately 30 minutes later. Review of the log revealed an entry at the very bottom of the page, below all entry lines, which listed Resident #3 by only his first name. The entry lists the resident as admitted from the local hospital, with no date of admission documented. The administrator had no explanation for the lack of required documentation on the log, other than saying the resident has only been at the facility for "about 2 weeks", and that she has decided she will not be keeping the resident long term as he is a risk.	A 160		
A 162 SS=D	Class III 59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case	A 162		

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A 162	Continued From page 4 of an emergency; and, 9. Name, address, and telephone number of the resident's health care practitioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, _____, or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A _____ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their _____ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that _____ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C.	A 162		

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A 162	Continued From page 5 (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an _____ recipient, a copy of the Department of Children and Families form Alternate Care Certification for _____, _____, CF-ES 1006, _____, which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's _____, DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but	A 162			

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A 162	Continued From page 6 who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to maintain resident records with required components of resident demographics, resident care, resident consent for assistance with self-administration of medications, and resident's contract with the facility for 1 of 2 sampled residents. (Resident #3) The findings are: During a tour of the facility beginning at 10:40 AM on _____, Resident #3 was observed ambulating to the living room from his bedroom. He had a large _____ in place to his left upper arm, and multiple _____ noted to both _____. The facility administrator stated he is a new resident and has only been at the facility for "about 2 weeks", and was admitted from the local hospital.	A 162		

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A 162	Continued From page 7 On ... at 2:05 PM, the administrator was asked for Resident #3's record. She stated that all she had for this resident was his Resident Health Assessment form (AHCA Form 1823). She confirmed that she has no written contract for services, no resident demographic information, no resident care or ... record, nor a consent for assistance with self-administration of medications. She stated "this is all I have" while presenting the AHCA Form 1823. She stated she has "not really admitted him yet", and has decided she will likely not be keeping Resident #3 at the facility as he has been identified as a ... risk on his AHCA Form 1823. She acknowledged the resident has resided at the facility for "about 2 weeks", and has been receiving services from facility staff during that time. The record has no information related to the ... observed in place to his upper left arm such as how long the ... has been in place, who is responsible for ... changes, nor any other details regarding any injury to his arm. Review of the facility Admission/Discharge Log revealed an entry at the very bottom of the page, below all entry lines which listed Resident #3 by only his first name. The entry lists the resident as admitted from the local hospital, with no date of admission documented. Class III	A 162		
A 165 SS=D	429.23(... & ...) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.-	A 165		

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A 165	Continued From page 8 (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. _____ ; 2. _____ or _____ damage; 3. Permanent _____ ; 4. _____ or _____ of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of	A 165		

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A 165	Continued From page 9 the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) Neglect, or abuse, must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this	A 165		

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A 165	Continued From page 10 section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to submit required Adverse Incident reports in the required timeframe for 2 of 2 residents reviewed for . (Residents #2 and #3) The findings include: Resident #3 During a tour of the facility beginning at 10:40 AM on , Resident #3 was observed ambulating to the living room from his bedroom. He had a large in place to his left upper arm, and multiple noted to both . The facility administrator stated he is a new resident and has only been at the facility for "about 2 weeks", and was admitted from the local hospital. An interview with the administrator on at 2:05 PM revealed Resident #3 " off the toilet last Friday", and was sent to the hospital by ambulance and was returned to the facility the same day by his daughter. When he returned to the facility, he had a in place to his upper left arm. The administrator was asked for the Adverse Incident Report for this event. She stated she had not filed a report and asked if she needed to do so now. She was not able to explain why a report had not been filed for this incident.	A 165		

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A 165	Continued From page 11 During a review of the Resident Health Assessment form (AHCA Form 1823), it was revealed that the section for "Physical or Sensory Limitations" is marked " . Risk". In addition, "Special Precautions" lists " precautions". The form also lists the resident as "supervision" required for all activities of daily living (ADLs). Resident #2 A review was conducted of the Resident Observation Log for Resident #2. In a note dated , it stated, " out of bed and said that nothing did not hurt her. We picked her up and put her on the bed. We took her to the hospital to get her checked. The hospital checked her and told us her arm was . They did all kinds of ." A review of the Adverse Incident reporting database was conducted which failed to reveal an Adverse Incident Report for Resident #2's , which resulted in bone and a transfer to an acute care hospital. On at 2:24 PM, an interview was conducted with the Administrator. When asked why an Adverse Incident Report was not submitted for Resident #2's she stated, "We did not do an Adverse Incident report. She did not . It is in the chart she didn't . I did not realize that I needed to." She was directed to the note in the Observation Record stating that the resident , went to the hospital, and was diagnosed with a arm. She then stated that she understood it should have been reported. Class III	A 165		