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
	AL11969794	A. BUILDING: _____ B. WING _____	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRABELLE	7400 SW 88TH ST MIAMI, FL 33156

(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 Two complaint investigations (#2026003079 & #2026006802) were conducted from through at Mirabelle. The provider had deficiencies at the time of the survey.	A 000		
A 032 SS=G	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 facility staff and law enforcement as necessary.	A 032		

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A 032	Continued From page 1 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, record review and interview, the facility failed to ensure one (Resident #29) out of 48 sampled residents assessed at risk for elopement or with any history of elopement was identified so staff can be alerted to his needs for support and supervision. The facility failed to follow the individual service plan for Resident #29 at risk for elopement. The facility failed to make at minimum a daily effort to	A 032		

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A 032	Continued From page 2	A 032		

determine at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number.

Findings:

A review of Resident #29's progress noted dated revealed: "At approximately 11:53 AM, [Resident #29] was observed walking in the hallway on the 9th floor. When asked where he was going, he stated that he was going to buy some items with his wife. The Resident's wife (Resident #37) was observed in the hallway along with the private aide. When approached and asked about [Resident #29], they stated that he had taken his care keys and they were unable to stop him. Shortly afterwards, when staff attempted to intervene, [Resident #29] was already inside the elevator. Memory Care Director was notified, and the elopement protocol was activated."

A review of the facility's individual service plan for Resident #29 revealed: "Resident may only leave the community on outings with staff, family, or a friend. It is unsafe for resident to leave unescorted, but resident has no history of attempting to leave unescorted. Apply an identification bracelet. Place in secured neighborhood. Inform staff of exit seeking behaviors."

Interviewed on at 9:38 AM when asked if he worked the day of the elopement, the Staffing Coordinator stated, "Yes." The Staffing Coordinator stated that Resident #29 and Resident #37 lived in the same apartment. in the same apartment. The Staffing Coordinator stated that he asked Resident #29 where he was going and Resident #29 told him he (Resident #29) was

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A 032	Continued From page 3 going to the store and wash his car. The Staffing Coordinator stated that he (Staffing Coordinator) asked the wife (Resident #37) and she said that it was okay for him to go." When asked if he knew Resident #29 was an elopement risk, the Staffing Coordinator stated, "I did not know he was an elopement risk. The Staffing Coordinator stated, "I informed the Memory Care Director that he was going to the store. When asked what the Memory Care Director said when he informed her that Resident 329 was leaving, the Staffing Coordinator stated that the Memory Care Director stated that it was okay. Interviewed on at 10:41 AM when asked why Resident #29 was allowed to leave, the Memory Care Director stated that his wife and daughter allowed him to. The Memory Care Director stated, "We never lost him." The Memory Care Director stated that the police were not involved when asked. The Memory Care Director stated that the wife (Resident #37) and Private Duty Aide never left with him (Resident #29). When asked why he remained with his car keys after the incident, the Memory Care Director stated that the keys were taken away after the incident. However, a review of Resident #29's progress notes dated showed the car keys were relinquished to staff. Interviewed on at 7:22 AM :22 AM when asked about resident elopements, the Assistant Executive Director stated, "We had a situation. The person never made it out of the building. I have to look at the names. We had a situation where the wife let him (Resident #29) out. After that, we took away his keys. We spoke to the wife. We trained the staff. We talked to staff. We do more rounds." When asked what Room Resident #29 was in, the Assistant	A 032		

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A 032	Continued From page 4 Executive Director stated, " ." However, the eight floor was the Memory Care floor, which was a secure floor. Observation on at 10:28 AM found Resident #29 without ID bracelet (facility's information) required for elopement risk. Interviewed on at 10:28 AM Resident #29's wife (Resident #37) stated that [Resident #29] did not have an ID bracelet and that her daughter monitored [Resident #29] through an app on her (daughter's) phone. Interviewed on at 1:01 PM when informed Resident #29 was without an ID bracelet, The Memory Care Director stated that they put on the information and they take it off. The Memory Care Director stated further, "I put it on daily." A review of the facility's elopement response plan showed: "the resident is given an identification bracelet with the community's name, address and phone number on it." A review of Resident #29's health assessment dated showed a diagnosis of Type II . The Resident was listed as an elopement risk. The status showed awake, alert and oriented times three with at times. The resident activities of daily living showed assistance needed with ambulation, bathing, , eating, self-care, toileting and transferring. Class II	A 032		