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
	AL11969400	A. BUILDING: _____ B. WING _____	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING LLC	496 SE VERADA AVE PORT SAINT LUCIE, FL 34983

(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, Complaint #2019017521, was conducted on through at , Living LLC. The facility had deficiencies identified at the time of the survey.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . 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. 59A-36.007 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 59A-36.012, 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	A 025		

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A 025	Continued From page 1 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 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 interview and record review, the facility failed to provide appropriate personal supervision for its residents which resulted in 1 out of 7 sampled residents (resident #7) to elope and become injured and required hospitalization. The facility also failed to implement its service plan policies and procedures by not ensuring its direct care staff remained awake during the overnight shift to deliver uninterrupted oversight service to the residents. The findings included: A review of the facility's undated "hours of operation/service plan" policies and procedures indicated that its staff members scheduled to work the overnight 11pm to 7am shift were to remain awake. Further review of this document indicated that the facility's staffing patterns were in place to ensure the residents' "uninterrupted service delivery".	A 025		

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A 025	Continued From page 2 In an interview with the Administrator on 11-14-19 at 12:25pm, she stated, Resident #7 eloped from the facility on the evening of or the early morning of . The administrator reported, on on or about 12:10 AM, a police officer came to the facility to report that Resident #7 was recently found in the middle of the street and taken to the hospital. She stated, Staff A, a facility caregiver, was the only staff member in the facility at the time of the incident and responsible for the 6 residents (Resident # and #7) residing at the facility. Based on resident record review, Resident #7 was admitted to the facility on . Resident #7's Health Assessment (Agency for Health Care Administration (AHCA) form 1823) dated on indicated that the resident was diagnosed with and had poor memory. Further review of the AHCA form 1823 indicated that the resident was an elopement risk and needed supervision with bathing, eating, grooming, toileting and transferring. Further review of this health assessment indicated that the resident needed daily oversight and observation with her whereabouts and wellbeing. In an interview with the Administrator on 11-14-19 at 2:00PM, she stated, Staff A likely asleep on which consequently led to Resident #7 being able to leave the facility undetected. She stated, that the facility "hours of operation/service plan" policies and procedures required every staff member working the overnight shift to remain awake and alert for the residents' continued care needs through the night. In an interview with Staff A on 11-14-19 at 3:10PM, she stated, she saw Resident #7 on	A 025		

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A 025	Continued From page 3 at around 8:00pm, while the resident was talking on the telephone with her daughter. After Resident #7 finished the telephone conversation, she then walked with the resident to bed so the resident could go to sleep at around 10:30pm. She stated, after putting the resident to bed, she went to the living room to lie down on the couch and asleep. She stated, shortly after midnight on , a Police Officer knocked on the facility's front door and questioned her about Resident #7 eloping from the facility. She reported, the Police Officer told her that the resident was found in the middle of the street and was transported to the hospital that morning. She stated that she was supposed to have activated the front door alarm to alert her, if any resident walked out the facility. She further stated, she was not supposed to have asleep that evening so she could maintain oversight of the residents, including Resident #7, who was diagnosed with and In an interview with Resident #7's daughter on at 3:05PM, she reported, the police officer found Resident #7 in the middle of a street intersection about a away from the facility on around 12:05AM. She stated, although the police report indicated that Staff A said that the resident attempted to leave the facility earlier on and she believed that this was false because she communicated with the resident on and was certain that this did not happen. She further stated, Resident #7 was hospitalized on because she had a painful and , which required her to be treated with medication due to injuries sustained during the elopement. She stated, the resident was discharged from the hospital on and placed in a nursing home for physical	A 025		

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A 025	Continued From page 4 rehabilitation services. Review of Resident #7's hospital record dated at 12:25 AM (0025 hour) showed, resident #7 had a history of was transported by Emergency Medical Services ( ) on for a . This record indicated the resident had a and on her right side; the resident reported she hit her . The resident reported constant , to her and right , at a level of 9 out of 10. Further review of this record indicated that the resident was ordered to be admitted to the hospital on at 2:15am for observation and diagnostic laboratory results and imaging studies. Further review of this record indicated the plan was for the resident to be discharged from the hospital on and to be admitted to a nursing home. Review of the police report dated on indicated, the police officer found Resident #7 lying supine in the middle of the intersection. This police report indicated the policer officer received information from a witness who saw the resident earlier that morning attempting to crawl on the street and informed the officer that the resident told her that the resident lived in a nearby assisted living facility. This report indicated that the officer was aware of the nearby facility, which was identified as " , Living LLC" and was about one away from that intersection. This police report indicated the resident was transported to the hospital by the emergency personnel and the police officer immediately visited the facility and found the front door "wide open" and the interior of the facility to be dark. This police report indicated that the police officer verbally announced her presence through the facility doorway and no one	A 025		

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A 025	Continued From page 5 answered, and then staff A responded to the front door after the officer rang the doorbell. The police report indicated that staff A appeared to have just been awakened and she confirmed that Resident #7 lived in the facility and she was not aware that the resident eloped from the facility earlier that morning or in the evening of . . The police report indicated Staff A told the police officer that the resident had . . . . 's . . . . . and and had attempted to escape from the facility earlier that day. Class I	A 025		
A 032 SS=J	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	A 032		

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A 032	Continued From page 6	A 032		

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. 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)(l), F.S.

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A 032	Continued From page 7 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop a written detailed resident elopement policy and procedure for training it's staff, to adequately identify residents at risk for elopement and to maintain personal identification on all at-risk residents. This failure affected 6 out of 7 sampled residents (Residents 1, 2, 3, 4, 5 and 7). Resident #7 eloped from the facility, sustained injuries and required hospitalization. Cross reference A 0025 The findings included: Record review of the facility's undated elopement policies and procedures titled, " ˻ and or elopement policy," indicated the Administrator was to assess all residents to determine who was at risk for ˻ and/or elopement at the time of admission. Review of this policy and procedure did not indicate that the facility staff must ensure that every at-risk resident have personal identification on their person that included their name, the facility's name, address, and telephone number. Further review of this policy and procedure indicated the staff must be trained on resident elopement standards upon orientation and staff compliance and participation was to be assessed twice yearly. Review of the elopement policy and procedure and the facility records did not indicate that the staff were required to conduct any resident elopement drills. Review of Resident #7's Health Assessment form dated (Agency for Health Care Administration (AHCA) form 1823) revealed, the resident suffered from , ´ and had a poor memory. The AHCA form also noted Resident #7 was an elopement	A 032		

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A 032	Continued From page 8 risk and the resident needed daily oversight and observation with her whereabouts and wellbeing. Further review of the facility records, resident #7's hospital records and police report revealed, the resident eloped from the facility in the evening of or the early morning of . The resident was located by police and a bystander about a away from the facility with no identification on her. Staff A, a facility caregiver, was the only staff member on duty was not aware Resident #7 eloped from the facility until police notifed her around 12:10 AM on at the facility. Resident #7's police report indicated that the police officer verbally announced her presence through the facility doorway and no one answered, and then staff A responded to the front door after the officer rang the doorbell. The police report indicated that staff A appeared to have just been awakened and she confirmed that Resident #7 lived in the facility and she was not aware that the resident eloped from the facility earlier that morning or in the evening of . The police report indicated Staff A told the police officer that the resident had 's and and had attempted to escape from the facility earlier that day. During an interview with the Administrator on at 1:40PM, she stated, she visually assessed Resident #7 for elopement risk on and she determined that the resident was at risk for elopement. She stated, she based her assessment on the resident's health assessment dated for which confirmed that the resident was at risk for elopement. She stated, she did not document any of her findings from her visual assessment in the resident's record. She stated, she did not perform any resident re-evaluations specific to this condition since	A 032		

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A 032	Continued From page 9 . . . . . She stated, she was aware that the facility elopement policies and procedures required her to perform elopement assessments on all of the facility residents, but she did not document any of these assessments for any of the residents in the facility. Further record review of Resident #1 - #5's file revealed, diagnoses of . . . . . , ... , and . . . . cognition. These diagnoses also place the residents at-risk for elopement without the proper assessment and identification. The facility's Administrator, according to the facility's elopement policy, had not assessed residents #1 - #5 for their potential elopement risk. In an interview with the Administrator on 11-14-19 at 1:50PM, she stated, the facility implemented the use of a front door alarm to alert the staff if anyone opened this door and she told all the staff members to activate this alarm every night. She stated, she was aware that this door alarm was presently not working properly because it was either not aligned properly or its battery ran out on the day Resident #7 eloped from the facility. During an observation at this time, the front door alarm was still not functional and it did not beep or make any noise upon opening the door. During further interview with the Administrator on at 2:00pm, she confirmed, Resident #7 did not have any identification on her when she eloped from the facility on and that the facility policies and procedures did not address this requirement. She stated, she was aware that this was necessary for the staff to ensure that every at-risk resident had identification on their person that included their name, the facility's name, address and telephone number, in the	A 032		

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A 032	Continued From page 10 event a resident eloped, was found by another person and the person would know where the resident lived. Record review of facility records failed to demonstrate elopement drills with staff participation had been conducted. In an interview with the Administrator on 11-14-19 at 2:20PM, she stated, the facility did not perform any elopement drills or training for its staff since it was initially licensed on . She stated, the facility's policies and procedures also did not specifically address the facility's requirements for conducting elopement drills and training for the staff. During an interview with staff A, a facilty caregiver on at 3:10PM, she stated that the facility did not offer her any elopement-specific training or drills since she was hired there in . She stated, she was not aware that Resident #7 was an elopement risk. She was aware that she was supposed to activate the front door alarm every night for the safety of all residents. She stated, the Administrator verbally told her about the door alarm having to be activated every night for the safety of all the residents. During an interview with Staff B, a caregiver on at 3:30PM, she stated, the facility did not provide her any elopement-specific training or drills since she was hired there in . She stated, she was not aware which residents presently in the facility were an elopement risk. She stated, she was not aware of the facility's elopement policies and procedures. She stated, the Administrator verbally told her about the door alarm having to be activated every night for the safety of all the residents.	A 032		

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A 032	Continued From page 11 Review of Staff A's employee record indicated that she was hired on . and she did not have elopement-specific training or drill certificates in the record. Review of staff B's employee record indicated that she was hired on . and she did not have elopement-specific training or drill certificates in the record. Class I	A 032		
A 081 SS=J	59A-36.011( ) FAC Training - Staff In-Service (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or	A 081		

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A 081	Continued From page 12 home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living.	A 081		

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A 081	Continued From page 13 (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide staff in-service training to 4 out of 4 staff members (Staff A, B, C and D) within 30 days of employment which included its staff to demonstrate understanding and competency in the implementation of the facility's elopement response policies and procedures. This failure resulted in staff A not following resident elopement standards which may have prevented the elopement of 1 out of 7 residents (Resident #7). Cross reference A 0025 & A 0032 The findings included: During an interview with the administrator on at 12:25pm, she stated, resident #7 eloped from the facility in the evening of or the early morning of because on on or about 12:10am a police officer came to the facility to report that resident #7 was found in the middle of the street and taken to the hospital.	A 081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969400	A. BUILDING: _____ B. WING _____	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING LLC	496 SE VERADA AVE PORT SAINT LUCIE, FL 34983

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A 081	Continued From page 14 During an interview with the administrator on at 2:20pm, she stated, the facility did not perform any elopement drills or training for any of its staff members since it was initially licensed on . She stated, the facility policies and procedures also did not specifically address the facility's requirements for conducting elopement drills and training for the staff. Review of resident #7's health assessment dated on indicated that the resident was diagnosed with and had a poor memory. Review of this health assessment indicated that the resident was an elopement risk and needed supervision with bathing, , eating, grooming, toileting and transferring. Further review of this health assessment indicated that the resident needed daily oversight and observation with her whereabouts and well being. In an interview with staff A, a caregiver on at 3:10pm, she stated, the facility did not offer her any elopement-specific training or drills since she was hired there in . She stated, she did not receive an in-service training within 30 days of initial employment to include resident care specific issues. She stated, she was not aware that resident #7 was specifically an elopement risk but she was aware she supposed to activate the front door alarm every night for the safety of all residents. Review of staff A's employee record indicated that she was hired on and she did not receive any elopement-specific trainings or drills. Further review of this record indicated that the staff did not receive in-service training or certificates that covered resident rights, recognizing and reporting	A 081		

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A 081	Continued From page 15 resident , neglect, and , and the facility's resident elopement response policies and procedures within thirty (30) days of employment. During an interview with staff B on 11-14-19 at 3:30pm, she stated, the facility did not provide her elopement-specific training or drills since she was hired on . She stated that she was not aware which residents presently in the facility were an elopement risk. She stated, she was not aware of the facility's elopement policies and procedures. She stated, the administrator verbally told her about the door alarm having to be activated every night for the safety of all the residents. Review of staff B's employee record indicated that she was hired on and she did not receive any elopement-specific trainings or drills. Further review of this record indicated that the staff did not receive in-service training and certificates that covered resident rights, recognizing and reporting resident , neglect, and , and the facility's resident elopement response policies and procedures within thirty (30) days of employment. Review of staff C's employee record indicated that she was hired on and she did not receive any elopement-specific trainings or drills. Further review of this record indicated that the staff did not receive in-service training and certificates that covered resident rights, recognizing and reporting resident , neglect, and , and the facility's resident elopement response policies and procedures within thirty (30) days of employment. Review of staff D's employee record indicated	A 081		

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
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A 081	Continued From page 16 that he was hired on and he did not receive any elopement-specific trainings or drills. Further review of this record indicated that the staff did not receive in-service training and certificates that covered resident rights, recognizing and reporting resident , neglect, and , and the facility's resident elopement response policies and procedures within thirty (30) days of employment. Class I	A 081		