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
	AL11953272	A. BUILDING: _____ B. WING _____	07/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD RETIREMENT CENTER	1220 JIMMY ANN DRIVE DAYTONA BEACH, FL 32117

(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 Control Focused survey and complaint investigation (complaint number 202001287) was conducted at Lakewood Retirement Center on . . , . . -30, 2020. The facility had deficiencies at the time of the survey.	A 000		
A 032	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 record review and staff interview, the facility failed to accurately assess the elopement risk necessary safety precautions in place for 1 of 3 sampled residents (Resident #1). The findings include:	A 032		

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A 032	Continued From page 2 1. During an interview with the Administrator on at 12:00 PM, she was asked to provide evidence of the elopement drills for the facility. The Administrator's Assistant provided evidence of an elopement in-service training dated in of 2019. Seven employees signed from to they received the training. There was no evidence on the paperwork provided to show an elopement drill was conducted. On at 12:18 PM, the Assistant was notified she had not provided evidence of elopement drills. She stated she did not have anything else to provide and directed the question to the Administrator. During further interview with the Administrator on at 1:14 PM, she stated when they did the in-service, they did a drill on each day. She stated she did not keep a record of the drill. She was asked if she did any drills in 2020 and she stated she did not. She was asked if they did any drills other drills in 2019 and she stated, "I don't think so." 2. During an interview with the Administrator's Assistant on at 9:30 AM she was asked to provide the adverse incidents reported by the facility. Record review found one adverse incident for Resident #1. Record review of the adverse incident report #530175 revealed on between 12:40 PM and 1:15 PM, Resident #1 was found by a neighbor attempting to cross the	A 032		

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road in front of the facility. The neighbor contacted the police and they transported the resident to the facility at 1:14 PM. The caregiver at the facility at the time of the elopement was interviewed. She stated she did not see Resident #1 go through the gate. The road in front of the facility was observed on at 8:30 AM and at 2:10 PM and was found to be a busy street and was not located in a neighborhood.

Record review of the facility record for Resident #1 found he was admitted to the facility on . Record review of the most recent AHCA 1823 Health Assessment found it was based on a examination. Resident #1 was diagnosed with unspecified , spectrum and other and a history of . His and behavioral status was alert and oriented to person and place and can follow verbal instructions. He needed reminders to stay on task. He continues to pace and is easy to direct. He is independent in ambulation, , eating, grooming, and transferring. He needs supervision in bathing and assistance in toileting. He needed general oversight and his whereabouts needed to be observed daily. Resident #1's elopement risk was checked, "no."

Record review of the progress notes in Resident #1's file revealed the following:

On at 12:17 PM, "Resident continues to be exit seeking. grounds all day. Resident has been pulling on the gate."
On at 11:08 AM, "Resident continues to be exit seeking. Pulling on gate. Resident is not always easy to redirect."
On at 10:14 AM, "Resident has

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continued to be exit seeking again this morning. Pulling on gate."
On [redacted] at 9:47 AM, Resident #1, "Continues to exit seek. Pulling on gate. Staff monitors where about constantly. Resident also continues to attempt to get in staff and visitor's cars. Extremely difficult to redirect."
[redacted] at 12:03 PM, the caregiver on duty witnessed Resident #1 climbing to the top of the gate attempting to get out of facility grounds.

During an interview with the Administrator on [redacted] at 1:14 PM she was asked about a [redacted] elopement. She could not recall a date but stated one time Resident #1 climbed over the fence near the gate. The employee saw him that day. One day another staff member saw Resident #1 with his [redacted] over the same fence and he stood up on the platform. She stated they did one to one with him for a long time. She was asked if she had any records of when the one on one occurred and she stated she did not have any records. She was asked what they did in [redacted] due to his exit seeking. She stated, "We called everyone and no one would take him." During the interview the Administrator was informed the most recent AHCA 1823 for Resident #1 showed he was not an elopement risk. The Administrator pulled out an AHCA 1823 from Resident #1's record and stated Resident #1 had been an elopement risk since he came to the facility. Record review of the AHCA 1823 revealed it was based on a [redacted] evaluation and elopement risk was check as a yes.

During further interview with the Administrator stated on [redacted] at 1:44 PM she was asked again if she had an incident report or anything to show how they investigated Resident 's elopement and what they put into place. She

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A 032	Continued From page 5 stated she did not have anything but would continue to look. A telephone interview was held with the Administrator on [redacted] at 11:45 AM. She was asked if she could recall another time the police brought Resident #1 [redacted] to the facility. She stated, she recalled an incident on when the resident got out and the police brought him [redacted]. She stated that he was about three blocks from the facility. She stated she could not figure out how he got out and informed the police that they had just fixed the gate. She stated the Department of Children and Families caseworker came out a couple of times to talk to Resident #1. He said he just wanted to go out. She was asked if there was any other time Resident #1 eloped from the facility and the police brought him [redacted]. She stated there was one time an employee left around 8:00 PM and they could not locate the resident. The looked all around the property and a neighbor behind the property motioned to her she had seen him and called the police. She stated the police came and she went with them to bring him [redacted]. She could not remember when the elopement occurred. She stated it was before the [redacted] elopement but she did not know the month. Class III	A 032		
A 079	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and	A 079		

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Respite Care Residents Staff Hours/Week
0-5 168
[illegible] 212
16-25 253
26-35 294
36-45 335
46-55 375
56-65 416
66-75 457
76-85 498
86-95 539

For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.
2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and [illegible]
( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or

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A 079	Continued From page 7 courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with	A 079		

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A 079	Continued From page 8 the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs.	A 079		

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A 079	Continued From page 9 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain enough staff to provide for the scheduled and unscheduled service needs, which has potential to affect all residents of the facility. The findings include: The facility was entered on at 8:30 AM. During an interview with the Administrator at the time of entry she stated she was the only one working at the facility. She stated the staff member that was supposed to come in had to stay over at the other facility she worked so she would not have a caregiver until 2:00 PM. During a tour of the facility on at 8:40 AM five residents were observed sitting in a room of the facility. The residents had not eaten	A 079		

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A 079	Continued From page 10 breakfast. On . . . . . at 8:50 AM the Administrator stated she needed to go serve breakfast and take care of the residents. The Assistant to the Administrator arrived on . . . . . at 9:00 AM. During an interview with the Assistant on at 9:05 AM, she stated she did not provide any resident care. She stated if a resident came to the desk and asked for something, she would get it for them. During further interview with the Administrator on at 9:07 AM, the Administrator stated the front door to the facility is always kept unlocked and residents are able to go in and out when they want. During another interview with the Administrator's Assistant on at 12:35 PM, the Assistant was asked for the employee schedules . . . through . The Assistant provided the schedules. Record review of the schedules found the current weeks schedule for the week of . . . . . through . . . . . and the weeks of through , through . . . . . were blank. A review of the schedule for through found the hours on the schedule totaled 113.25 out of the required 211 hours per week. On there were not any employees scheduled. On . . . . . there was only one employee scheduled from " PM." During further interview with the Assistant on . . . . . at 12:45 PM she was notified the schedules from forward were blank. She stated she did not have the time to do the schedules. She provided a piece of paper that had first names and the days of the week. The paper did not have times or dates. She stated the staff always come in the same time. She was informed that there were some days that did not	A 079		

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A 079	Continued From page 11 have coverage and there was no one working at night. She stated the Administrator does the overnight shift and she does not include her on the schedule. The incident report for an elopement of Resident #1 was reviewed. The narrative of the incident report revealed Resident #1 was found by a neighbor on . . . . . The neighbor contacted the police and the resident was brought to the facility. The facility had not been aware the resident had eloped until he was brought by the police. Record review of the progress notes for Resident #1 found on Resident #1 was exit seeking and had attempted to climb to the top of the gate and get out. There were also notes on , ... and . . . . . documenting the resident was trying to get out of the gate. During a telephone interview was held with the Administrator on at 11:45 AM, she was asked if she could recall another time the police brought Resident #1 to the facility. She stated recalled an incident on . . . . . when the resident got out and the police brought him . She stated, Resident #1 was about three blocks from the facility at the time. She stated when he was brought she could not figure out how he got out and informed the police that they had just fixed the gate. She stated the Department of Children and Families caseworker came out a couple of times to talk to Resident #1. He said he just wanted to go out. They looked around the entire property and could not figure out how he got out. She stated the put him on one on one for about a week. They sent the bill to the daughter and she did not want to pay it because she thought it should be covered by the facility. She stated they looked for another place for him to go	A 079		

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A 079	Continued From page 12 and stopped the one on one because the daughter refused to pay for it. She was asked if there was any other time Resident #1 eloped from the facility and the police brought him . She stated there was one time an employee left around 8:00 PM and they could not locate the resident. The looked all around the property and a neighbor behind the property motioned to her she had seen him and called the police. She stated the police came in the meantime and she went with them to bring him . . . A review of the facility elopement policy and procedures revealed under 4. Staff would institute a search of the grounds. Two staff members would exit the facility and circle around the building, meeting again at their exit point. This procedure could not be done based on the staffing at the facility based on the facility schedules and the observation of staffing on . . . . . . Photographic evidence obtained Class III	A 079		
A 161	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this	A 161		

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A 161	Continued From page 13 part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in section 429.174, F.S., and rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most	A 161		

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	AL11953272	A. BUILDING: _____ B. WING _____	07/30/2020

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A 161	Continued From page 14 current 6 months as required by rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain written work schedules documenting the hours worked to care for the 11 residents that reside in the facility. The findings include: During an interview with the Administrator's Assistant on at 12:35 PM, the Assistant was asked for the employee schedules through . The Assistant provided the schedules. Record review of the schedules provided revealed the current weeks schedule for the week of through and the weeks of through , through were blank. A review of the schedule for through found the hours on the schedule totaled 113.25. During further interview with the Assistant on at 12:45 PM she was notified the schedules from forward were blank. She stated she did not have the time to do the schedules. She provided a piece of paper that had first names and the days of the week. The paper did not have times or dates. She stated the staff always come in the same time. She stated the Administrator does the overnight shift and she does not include her on the schedule. Photographic evidence obtained	A 161		

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A 161	Continued From page 15 Class III	A 161		
A 165	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (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	A 165		

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A 165	Continued From page 16 (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, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of 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, by electronic mail, facsimile, or United States 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 , 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	A 165		

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A 165	Continued From page 17 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 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. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on staff interview, observation and record review, the facility failed to investigate and report two adverse incidents for a resident that eloped from the facility and failed to report within one business day after the third elopement by the same resident. (Resident #1) The findings include:	A 165		

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A 165	Continued From page 18 During an interview with the Administrator's Assistant on [redacted] at 9:30 AM she was asked to provide the Adverse Incidents reported by the facility. A review of the Adverse Incident reports provided revealed one adverse incident for Resident #1. Record review of the adverse incident report #530175 revealed on [redacted] between 12:40 PM and 1:15 PM, Resident #1 was found by a neighbor attempting to cross the road in front of the facility. The neighbor contacted the police and they transported the resident to the facility at 1:14 PM. The caregiver at the facility at the time of the elopement was interviewed. She stated she did not see Resident #1 go through the gate. The road in front of the facility was observed on [redacted] at 8:30 AM and at 2:10 PM and was found to be a busy street and was not located in a neighborhood. A review of the facility record for Resident #1 found he was admitted to the facility on [redacted]. Record review of the most recent AHCA 1823 Health Assessment found it was based on a [redacted] examination. Resident #1 was diagnosed with unspecified [redacted], spectrum and other [redacted] and a history of [redacted]. His [redacted] and behavioral status was alert and oriented to person and place and can follow verbal instructions. He needed reminders to stay on task. He continues to pace and is easy to direct. He was independent in ambulation, [redacted], eating, grooming, and transferring. He needed supervision in bathing and assistance in toileting. He needed general oversight and his whereabouts needed to be observed daily. Resident #1's elopement risk was checked, "no."	A 165		

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A 165	Continued From page 19 Record review of the progress notes in Resident #1's file revealed the following: On at 12:17 PM, "Resident continues to be exit seeking grounds all day. Resident has been pulling on the gate." On at 11:08 AM, "Resident continues to be exit seeking. Pulling on gate. Resident is not always easy to redirect." On at 10:14 AM, "Resident has continued to be exit seeking again this morning. Pulling on gate." On at 9:47 AM, Resident #1, "Continues to exit seek. Pulling on gate. Staff monitors where about constantly. Resident also continues to attempt to get in staff and visitor's cars. Extremely difficult to redirect." at 12:03 PM, the caregiver on duty witnessed Resident #1 climbing to the top of the gate attempting to get out. During another interview with the Administrator's Assistant on at 12:49 PM, she stated the Administrator writes up the Adverse Incident reports and she puts them in the computer. She was asked to see if they did adverse incident reports for Resident #1 other than in , . She accessed the system and could not locate any other adverse incident reports for an elopement for Resident #1. During an interview with the Administrator on at 1:14 PM she was asked about an elopement other than on . She could not recall a date but stated one time Resident #1 climbed over the fence near the gate. The employee saw him that day. One day another	A 165		

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A 165	Continued From page 20	A 165		

staff member saw Resident #1 with his [redacted] over the same fence and he stood up on the platform. She stated they did one to one with him for a long time. She was asked if she had any records of when the one on one occurred and she stated she did not have any records. She was asked what they did in [redacted] due to his exit seeking. She stated, "We called everyone and no one would take him." During the interview the Administrator was informed the most recent AHCA 1823 for Resident #1 showed he was not an elopement risk. The Administrator pulled out an AHCA 1823 from Resident #1's record and stated Resident #1 had been an elopement risk since he came to the facility. Record review of the AHCA 1823 revealed it was based on a evaluation and elopement risk was check as a yes.

During further interview with the Administrator stated on [redacted] at 1:44 PM she was asked again if she had an incident report or anything to show how they investigated Resident #1's elopements prior to [redacted] and what they put into place. She stated she did not have anything but would continue to look.

During a telephone interview with the Administrator on [redacted] at 11:45 AM, she was asked if she could recall another time the police brought Resident #1 [redacted] to the facility. She stated, she recalled an incident on [redacted] when the resident got out and the police brought him [redacted]. She stated that he was about three blocks from the facility. She stated she could not figure out how he got out and informed the police that they had just fixed the gate. She stated the Department of Children and Families caseworker came out a couple of times to talk to Resident #1. He said he just wanted to go out. She was asked

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A 165	Continued From page 21 if there was any other time Resident #1 eloped from the facility and the police brought him . She stated there was one time an employee left around 8:00 PM and they could not locate the resident. They looked all around the property and a neighbor behind the property motioned to her she had seen him and called the police. She stated the police came in the meantime and she went with them to bring him . . . . She could not remember when the elopement occurred. She stated it was before the . . . . . elopement but she did not know the month. A review of the adverse incident reporting system revealed the adverse incident for the . . . . . elopement was created on and submitted to the agency on . . . . . and closed on . There were no other adverse incident reports for Resident #1 in the state system. Class III	A 165		
A 193	59AER20-4 Mandatory Testing for Assisted Living Facilit (1) APPLICABILITY. The requirements of this emergency rule apply to all assisted living facilities licensed under Chapter 429, F.S. (2) DEFINITIONS. "Staff" means all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or materials, including body substances (e.g., ... , tissue, and specific . , . . .); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. Staff may include, but are not limited to, nurses, nursing assistants,	A 193		

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A 193	Continued From page 22 physicians, technicians, , , , , pharmacists, students and trainees, contractual staff not employed by the health care facility, and persons (e.g., clerical, dietary, environmental services, laundry, security, maintenance, engineering and facilities management, administrative, billing, and volunteer personnel) not directly involved in patient care but potentially exposed to agents that can be transmitted among from staff and patients. This definition is consistent with the Centers for Control and Prevention definition of Healthcare personnel as defined in Appendix 2. ,. (3) MANDATORY STAFF TESTING FOR COVID-19. (a) Beginning , , , assisted living facilities shall not admit into the facility any staff who has not been tested for COVID-19. (b) Assisted living facilities shall require all staff be tested every two (2) weeks thereafter with testing resources provided by the state. (4) EXEMPTION FROM TESTING. Staff who have already been and recovered from COVID-19 do not need to be tested if they can provide medical documentation to the assisted living facility. (5) DOCUMENTATION. (a) If testing is conducted off-site, then staff must provide proof of testing to the assisted living facility. (b) Assisted living facilities shall document all staff testing, including the name of the individual, time, and date of the test. (c) Assisted living facilities shall require all tested staff to notify the facility of the test results the same day the results are received. Written documentation of test results must be provided to the facility upon receipt by the staff.	A 193		

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A 193	Continued From page 23 (d) Assisted living facilities shall keep copies of all staff testing documentation on site. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency may seek any remedy authorized by Chapter 429, Part I, or Chapter 408, Part II, F.S., including but not limited to, license revocation, license suspension, and the imposition of administrative fines. This Statute or Rule is not met as evidenced by: Based on staff interview and record review, the facility failed to provide COVID-19 testing for facility staff members as directed by the emergency rule beginning , , , mandating that all staff admitted to work at the assisted living facility (ALF) be tested for COVID-19 every two (2) weeks with testing resources provided by the state. The facility failure to adhere to the emergency rule put the 11 residents currently at the facility at risk for COVID-19. The findings include: During an interview with the Administrator's Assistant on at 9:30 AM, she stated the ALF has 6 employees including herself and the Administrator. She was asked if the facility was doing COVID-19 testing for the employees. She stated, "no". She stated they had not done any COVID-19 testing because they were having problems getting in the lab providers computer system. She further stated she had not been able to reach anyone with the company because she could not locate a phone number. She stated she and the Administrator had asked someone from the Agency for Health Care for help and were told to call the Department of Health. She was asked for the names of the individuals that she had	A 193		

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A 193	Continued From page 24 contacted for help and she did not have anything to provide. She stated they did not keep any records of who she had contacted for help. The Assistant stated they did have COVID-19 lab results for the employees. Record review of the paperwork provided revealed the facility had documentation of one negative lab result for each employee. The lab result for Employee A was dated . The lab result for Employee B was dated . The lab result for Employee C was dated . The lab result for Employee D was dated . The lab result for Employee E was dated and the lab result for Employee F was dated . During an interview on with the Administrator on at noon, she confirmed the facility had not done any COVID-19 testing for the employees or obtained evidence of test results for employees tested at other facilities since the emergency rule was in place. Class II	A 193		

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CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes to have an emergency operations plan must designate a safety liaison to serve as the primary contact for emergency operations. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved emergency operations plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan	CZ830		

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CZ830	Continued From page 1 for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) The agency may adopt rules relating to emergency management planning, communications, and operations. Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on an interview with the Administrator and the Administrator's Assistant and a review of the Agency for Health Care Administration Emergency Status System (ESS), the facility failed to ensure the safety of its 11 current residents, by failing to report the following information using the online database (ESS): facility census, available beds, inventory, needs, and other related information for Novel Coronavirus (COVID-19) daily by 10:00 AM, pursuant to Executive Order 20-51, and at the direction of the State Surgeon General, for 18 of 47 days reviewed.	CZ830		

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LAKEWOOD RETIREMENT CENTER	**1220 JIMMY ANN DRIVE DAYTONA BEACH, FL 32117**

(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
CZ830	Continued From page 2	CZ830		

The findings include:

During an interview with the Administrator's Assistant on at 9:24 AM, she was asked if she updated the Emergency Status System (ESS). She responded that she and the Administrator do it together every morning and try to do it before the 10:00 AM deadline. She was asked if she updated the system on weekends. She stated she did not work on weekends and that would be up to the Administrator. She logged on to ESS and confirmed the updates were not done on weekends.

During an interview with the Administrator on at 1:40 PM, she was asked if she updated ESS on the weekends. She responded that she did not.

Record review of the ESS submissions from through revealed the facility failed to make submissions on , , , , , , , , , , , , , , and .

Pursuant to the Governor's Executive Order 20-51, and at the direction of the State Surgeon General regarding Novel Coronavirus (COVID-19), the Agency for Health Care Administration opened the event "COVID-19 Monitoring" in the Emergency Status System to monitor assisted living facilities census, inventory, needs and other related information statewide. All assisted living facilities were required to report current resident census and available beds in their facilities by 10:00 AM and answer additional questions related to the facility status and

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
	AL11953272	A. BUILDING: _____ B. WING _____	07/30/2020

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CZ830	Continued From page 3 COVID-19. Notification to facilities was dated , Class III	CZ830		