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
	AL11964280	A. BUILDING: _____ B. WING _____	07/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA MANOR AT DAYTONA BEACH, LLC	252 FOREST LAKE BLVD DAYTONA BEACH, FL 32119

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A 000	Initial Comments A complaint investigation (complaint #2020011845, #2019019375 and #2020001972) was conducted in conjunction with a focused . . . . control survey and generator assessment at Magnolia Manor at Daytona Beach from . . , . . to . . , ... Deficient practice was identified at the time of the survey.	A 000		
A 010	429.26(&9) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (2) A physician, physician assistant, or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial	A 010		

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A 010	Continued From page 1 interest in the facility. (9) A , ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and,	A 010		

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A 010	Continued From page 2 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are	A 010		

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A 010	Continued From page 3 described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations, resident and staff interviews, and record reviews, the facility's Administration failed to ensure 1 of 8 sampled residents met continued residency criteria following multiple elopements that resulted in injury (Resident 2). The findings include: Record review for Resident 2 found she was admitted to the facility on . An Admission and Rental Agreement executed on noted under the "Services Provided" section that the resident would have access to staff 24 hours a day, 7 days a week. The contract did not specify the level of supervision the facility would provide to Resident 2. The record also contained a Negotiated Risk Agreement and Release that was signed by the resident, her designated Power of Attorney, the Wellness Director and Executive Director (Administrator) on ; the day after her admission. The agreement noted Resident 2 had advanced and was at risk for elopement ( ) from the facility unattended). The agreement specified the following: -Resident/Family Desire or Preference: Resident could possibly elope from the community, walk out the main entrance or other entry doors and could place herself into immediate danger. -Alternative approaches to minimize risk: Redirect the resident from the entry and exit doorways.	A 010		

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A 010	Continued From page 4 -Agreed course of action: If the resident does elope this community, the liability will reside with family of said resident. Elopement protocol will take effect immediately. However, based on severity of elopement, (facility) may have to ask resident to move into more secure location. Records contained a facility report detailing an occurrence on [redacted] at approximately 11:12 am. Two individuals from the adjacent neighborhood had found Resident 2 knocking on their door. Resident 2 was able to report her name, but not her birth date or her address. The couple, along with a law enforcement officer, escorted Resident 2 [redacted] to the facility where she was positively identified by staff. Resident 2 had last seen by facility staff at approximately 10:15 am that morning. The reporter assumed Resident 2 followed another resident outside to the front porch, then [redacted] off and did not know how to return. The family was notified and were advised a 24-hour private sitter might be preferable. The facility also decided to implement an every 2-hour observation of Resident 2. One Hour Visual Check Logs were initiated for Resident 2 on [redacted]; however, review of the chart found they were only completed on [redacted] and [redacted]. Further review of the record found no additional interventions were implemented to ensure enough supervision for Resident 2 as result of her recent elopement. A History and Physical exam was completed for Resident 2 on [redacted] by the PA. He noted Resident 2 was [redacted] and had "eloped". He indicated his visit was after hours and unscheduled and had been requested by the facility in order for him to evaluate the resident secondary to her leaving the facility. It indicated	A 010		

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A 010	Continued From page 5 Resident (2) had . . . . , which the examiner noted as "fairly advanced". Resident 2 admitted to leaving, but did not recall anything. While the PA assessed that she could safely stay, he concluded by stating (we) discussed the need to keep a closer , on access and how she got out. He recorded a diagnosis of unspecified with behavioral disturbance An Elopement Risk Assessment dated assessed Resident 2 with daily disorientation and complacence and 's . . Total risk score was 11, and per the key codes, a score higher than 9 was at risk for elopement. A second facility report noted that on , Resident 2 eloped again and was found by a neighbor at approximately 4:15 am. She was lying on the ground next to a dumpster behind the facility. Resident 2 was taken to the hospital and found with . . . . . to her upper right forehead and right . . Investigation determined Resident 2 had pushed on the front doors, which have an automatic egress. She traveled to the rear of the facility and . . The Physician was notified, reviewed her medications but made no recommendations for changes. The front doors were determined to be working properly. A supporting nursing progress note dated and authored by the Wellness Director stated she was advised at 4:16 am that Resident 2 got out the front door and left the property. A neighbor came and advised that the resident was found lying on the ground by dumpsters. Employee A, Medication Technician and Residential Aid, recalled she last saw Resident 2 at 3:30 am (45 minutes prior to being found). Resident 2 was placed on every-hour visual checks for 7 days. The resident's records contained these visual	A 010		

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A 010	Continued From page 6 checks, which were documented for one week. There were no further interventions implemented after the 7-day increased supervision period. Photographic evidence was obtained of referenced documents. An observation and attempted interview was conducted with Resident 2 at 2:40 pm on . . . . . in her room. She did not engage in conversation appropriately and could not answer direct questions correctly. Resident 2's room was observed to have furniture, bathroom door, refrigerator and other items labeled with large print stickers identifying the item or its contents. Resident 2's room was in one of 2 front residential hallways, approximately 100 from the front door. An interview was conducted with Employee B, Residential Aide ( ), at 4:15 pm on . She stated Resident 2 was at risk for elopement and would pace at and watch the front door. Resident 2 insisted she did not live there and needed to get out. All of the facility doors were coded with a keypad for getting in and out. Only certain residents received that code and Resident 2 was not one of them. She cannot go out without supervision. The front door is a fire door and if you push it hard enough it will open to let you out. Employee B was not sure if the front door was alarmed. An interview with Employee C, Medication Technician (MT) at 4:26 pm on revealed Resident 2 was an elopement risk. She usually tried to get out of the facility on the 11:00 pm to 7:00 am (overnight) shift. Staff conducted one-hour checks when a resident was in the exit-seeking state, but none were being done at this time. Resident 2 recently got out on the	A 010		

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A 010	Continued From page 7 overnight shift. The front doors were not working. Resident 2 can read, and the doors have instructions on how to open them. Employee C was not sure if an alarm sounded when the front door was opened. Interview with Employee D, , at 4:45 pm on found Resident 2 and wanted to get out. She would insist her family was looking for her or that she was not supposed to be there. Hourly watches were initiated after a resident elopement. She was not sure if the front doors alerted staff when opened by a resident. The Administrator demonstrated the use of the two sliding glass doors at the facility's entrance on at 535 pm. The doors were observed to slide open only if a code was entered on the outside keypad, or if a staff member activated a switch from inside the building. They did not open automatically when approached. The Administrator explained the doors were wired so that in a fire, the bars could be depressed and held for 15 seconds. They would then would automatically release for emergency exit. Upon his demonstration, the door released within 3 seconds of depressing the emergency release bar. No alarm sounded. When asked how his staff, who might be working in the of the very large building, would know if a resident exited the double doors, he did not have an answer. An interview was conducted with the Wellness Director (WD) at 12:16 pm on . Resident 2 was at risk for elopement due to memory care issues and has had 2 elopements. One happened almost a year ago, she believed, and it was at night. Both aides were in assisting another resident when Resident 2 walked out and to the	A 010		

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A 010	Continued From page 8 nearby apartment . The second elopement occurred between 3:15 am and 3:30 am. The aide noticed the front door had been left cracked open. Her physician saw her and said there was nothing we could do about her behavior. When asked what other interventions had been implemented by the facility to ensure sufficient supervision for this resident, she could only relay the one-hour checks following the elopement. She could not state any other interventions for the increased supervision of this resident outside of the one-hour checks. Class III	A 010		
A 025	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 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 025		

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A 025	Continued From page 9 (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 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 observations, resident and staff interviews, and resident, facility and public record reviews, the facility failed to provide sufficient supervision appropriate to the resident's needs in order to prevent elopement for 1 of 8 sampled residents (Resident 2). The findings include: Record review for Resident 2 found she was admitted to the facility on . An Admission	A 025		

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A 025	Continued From page 10 and Rental Agreement executed on noted under the "Services Provided" section that the resident would have access to staff 24 hours a day, 7 days a week. The contract did not specify the level of supervision the facility would provide to Resident 2. The record also contained a Negotiated Risk Agreement and Release that was signed by the resident, her designated Power of Attorney, the Wellness Director and Executive Director (Administrator) on ; the day after her admission. The agreement noted Resident 2 had advanced and was at risk for elopement (from the facility unattended). The agreement specified the following: -Resident/Family Desire or Preference: Resident could possibly elope from the community, walk out the main entrance or other entry doors and could place herself into immediate danger. -Alternative approaches to minimize risk: Redirect the resident from the entry and exit doorways. -Agreed course of action: If the resident does elope this community, the liability will reside with family of said resident. Elopement protocol will take effect immediately. However, based on severity of elopement, (facility) may have to ask resident to move into more secure location. Records contained a facility report detailing an occurrence on at approximately 11:12 am. Two individuals from the adjacent neighborhood had found Resident 2 knocking on their door. Resident 2 was able to report her name, but not her birth date or her address. The couple, along with a law enforcement officer, escorted Resident 2 to the facility where she was positively identified by staff. Resident 2 had	A 025		

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A 025	Continued From page 11 last seen by facility staff at approximately 10:15 am that morning. The reporter assumed Resident 2 followed another resident outside to the front porch, then off and did not know how to return. The family was notified and were advised a 24-hour private sitter might be preferable. The facility also decided to implement an every 2-hour observation of Resident 2. One Hour Visual Check Logs were initiated for Resident 2 on ; however, review of the chart found they were only completed on , , , and . Further review of the record found no additional interventions were implemented to ensure enough supervision for Resident 2 as result of her recent elopement. A History and Physical exam was completed for Resident 2 on by the PA. He noted Resident 2 was and had "eloped". He indicated his visit was after hours and unscheduled and had been requested by the facility in order for him to evaluate the resident secondary to her leaving the facility. It indicated Resident (2) had , which the examiner noted as "fairly advanced". Resident 2 admitted to leaving, but did not recall anything. While the PA assessed that she could safely stay, he concluded by stating (we) discussed the need to keep a closer on access and how she got out. He recorded a diagnosis of unspecified with behavioral disturbance An Elopement Risk Assessment dated assessed Resident 2 with daily disorientation and complacence and 's Total risk score was 11, and per the key codes, a score higher than 9 was at risk for elopement.	A 025		

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A 025	Continued From page 12 A second facility report noted that on , Resident 2 eloped again and was found by a neighbor at approximately 4:15 am. She was lying on the ground next to a dumpster behind the facility. Resident 2 was taken to the hospital and found with to her upper right forehead and right . Investigation determined Resident 2 had pushed on the front doors, which have an automatic egress. She traveled to the rear of the facility and . The Physician was notified, reviewed her medications but made no recommendations for changes. The front doors were determined to be working properly. A supporting nursing progress note dated and authored by the Wellness Director stated she was advised at 4:16 am that Resident 2 got out the front door and left the property. A neighbor came and advised that the resident was found lying on the ground by dumpsters. Employee A, Medication Technician and Residential Aid, recalled she last saw Resident 2 at 3:30 am (45 minutes prior to being found). Resident 2 was placed on every-hour visual checks for 7 days. The resident's records contained these visual checks, which were documented for one week. There were no further interventions implemented after the 7-day increased supervision period. . Photographic evidence was obtained of referenced documents. An observation and attempted interview was conducted with Resident 2 at 2:40 pm on in her room. She did not engage in conversation appropriately and could not answer direct questions correctly. Resident 2's room was observed to have furniture, bathroom door, refrigerator and other items labeled with large print stickers identifying the item or its contents.	A 025		

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A 025	Continued From page 13 Resident 2's room was in one of 2 front residential hallways, approximately 100 from the front door. An interview was conducted with Employee B, Residential Aide ( ), at 4:15 pm on . She stated Resident 2 was at risk for elopement and would pace at and watch the front door. Resident 2 insisted she did not live there and needed to get out. All of the facility doors were coded with a keypad for getting in and out. Only certain residents received that code and Resident 2 was not one of them. She cannot go out without supervision. The front door is a fire door and if you push it hard enough it will open to let you out. Employee B was not sure if the front door was alarmed. An interview with Employee C, Medication Technician (MT) at 4:26 pm on revealed Resident 2 was an elopement risk. She usually tried to get out of the facility on the 11:00 pm to 7:00 am (overnight) shift. Staff conducted one-hour checks when a resident was in the exit-seeking state, but none were being done at this time. Resident 2 recently got out on the overnight shift. The front doors were not working. Resident 2 can read, and the doors have instructions on how to open them. Employee C was not sure if an alarm sounded when the front door was opened. Interview with Employee D, , at 4:45 pm on found Resident 2 and wanted to get out. She would insist her family was looking for her or that she was not supposed to be there. Hourly watches were initiated after a resident elopement. She was not sure if the front doors alerted staff when opened by a resident. The Administrator demonstrated the use of the two sliding glass doors at the facility's entrance	A 025		

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	AL11964280	A. BUILDING: _____ B. WING _____	07/23/2020

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A 025	Continued From page 14 on . . . . . at 535 pm. The doors were observed to slide open only if a code was entered on the outside keypad, or if a staff member activated a switch from inside the building. They did not open automatically when approached. The Administrator explained the doors were wired so that in a fire, the bars could be depressed and held for 15 seconds. They would then would automatically release for emergency exit. Upon his demonstration, the door released within 3 seconds of depressing the emergency release bar. No alarm sounded. When asked how his staff, who might be working in the . . . of the very large building, would know if a resident exited the double doors, he did not have an answer. An interview was conducted with the Wellness Director (WD) at 12:16 pm on . Resident 2 was at risk for elopement due to memory care issues and has had 2 elopements. One happened almost a year ago, she believed, and it was at night. Both aides were in assisting another resident when Resident 2 walked out and to the nearby apartment , . The second elopement occurred between 3:15 am and 3:30 am. The aide noticed the front door had been left cracked open. Her physician saw her and said there was nothing we could do about her behavior. When asked what other interventions had been implemented by the facility to ensure sufficient supervision for this resident, she could only relay the one-hour checks following the elopement. She could not state any other interventions for the increased supervision of this resident outside of the one-hour checks. Class III	A 025		

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A 032	Continued From page 15	A 032		
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 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	A 032		

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A 032	Continued From page 16 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. This Statute or Rule is not met as evidenced by: Based on staff interviews and facility record reviews, the facility failed to assess residents at risk for elopement per its own policies and procedures and failed to conduct and document resident elopement drills with all staff participation twice a year. The findings include:	A 032		

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A 032	Continued From page 17 1. Record review for Resident 2 found she was admitted to the facility on . Resident 2's record contained a Negotiated Risk Agreement and Release that was signed by the resident, her designated Power of Attorney, the facility's Wellness Director and the Executive Director (Administrator) on ; the day after her admission. The document reported Resident 2 had advanced and was at risk for elopement (from the facility unattended). It stated the if the resident did elope the community, the elopement protocol would take effect immediately. Facility records revealed that on at approximately 11:12 am, two people from the adjacent residential neighborhood found Resident 2 knocking on the door of their home. Resident 2 was able to report her name, but not her birth date or her address. The couple, along with a law enforcement officer, escorted Resident 2 to the facility where she was positively identified by staff. Resident 2 was reportedly last seen by facility staff at approximately 10:15 am that morning. The report noted it was assumed Resident 2 followed another resident outside to the front porch, then off and did not know how to return. A second report noted that on , Resident 2 eloped again and was found by a neighbor at approximately 4:15 am lying on the ground behind the facility next to a dumpster. She was taken to the hospital and found with to her upper right forehead and right . Investigation determined Resident 2 had pushed on the front doors, which have an automatic egress. She traveled to the rear of the facility and	A 032		

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A 032	Continued From page 18 . . An Elopement Risk Assessment dated assessed Resident 2 with daily disorientation and complacence and 's . She but does not leave the interior setting. Total risk score was 11, and per the key codes, a score higher than 9 was at risk for elopement. There were no further Elopement Risk Assessments in the record. Review of facility records found an Elopement/Missing Resident Policy (policy number 6.07) that had been last revised . It noted any resident identified as high risk for and with any significant change in or other abilities would be assessed monthly using a Risk Scale Form. Photographic evidence was obtained of referenced documents. A review of the facility's Elopement Drill logs found elopement drills were completed on (no year) and (no year), with a total of 7 staff members in attendance. The most recent elopement drill dated had only 8 staff in attendance. There was no documentation that all facility staff had participated in biannual elopement drills, as required. Review of the facility staff roster found there were 25 staff members employed in the facility at the time of survey. 2. An interview was conducted with Employee B, Residential Aide ( ), at 4:15 pm on . She stated she knew Resident 2 was at risk for	A 032		

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A 032	Continued From page 19 elopement and would pace at and watch the front door. She would insist she did not live there and needed to get out. When asked if she had participated in any elopement drills in this facility, she stated she had not. Interview with Employee D, , at 4:45 pm on ..... found Resident 2 ..... and wanted to get out. She would say her family was looking for her or that she was not supposed to be there. Employee D heard Resident 2 had gotten out before. When asked about her participation in facility wide elopement drills, Employee D stated she had not participated in any. An interview was conducted with the Wellness Director (WD) at 12:16 pm on ..... She stated the Administrator was responsible for the execution of elopement drills. She completed resident elopement risk assessments every 90 days. The WD was not aware of the facility's Elopement policy and procedure that stated monthly evaluations would be completed for residents at high risk. She had never seen the policy. The WD acknowledged that per the facility policy, Resident 2 should have monthly assessments completed. An interview was conducted with the Administrator at 1:40 pm on ..... He was shown the facility elopement drills and confirmed there was no documentation any were conducted in 2019, and no evidence that all staff had participated in elopement drills. He confirmed only one drill was executed in 2020 and not all staff had participated. He acknowledged that all staff was required to participate in elopement	A 032		

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A 032	Continued From page 20 drills twice a year and that Resident 2 was an elopement risk. The Administrator reviewed the Elopement/Missing Resident Policy and acknowledged Resident 2 had not been assessed monthly per the policy. Class III	A 032		
A 200	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure . . . . air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square . . per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed	A 200		

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A 200	Continued From page 21	A 200		

capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained.
2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code.
3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment.
a. An assisted living facility in an evacuation zone pursuant to chapter 252, F. S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted

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A 200	Continued From page 22 living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain . . . . temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to	A 200		

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A 200	Continued From page 23	A 200		

section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency.
3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule.
4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel.
(c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility.
(d) The acquisition and maintenance of a . . . . monoxide alarm.
(2) SUBMISSION OF THE PLAN.
(a) Each assisted living facility licensed prior to the effective date of this rule shall submit its plan to the local emergency management agency for review within 30 days of the effective date of this rule. Assisted living facility plans previously submitted and approved pursuant to emergency rule 58AER17-1 will require resubmission only if changes are made to the plan.
(b) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license.
(c) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or

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A 200	Continued From page 24	A 200		

reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the local emergency management agency for review and approval.
(3) APPROVED PLANS.
(a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request.
(b) Within two (2) business days of the approval of the plan from the local emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration.
(c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the local emergency management agency and update within ten (10) business days of implementation.
(4) IMPLEMENTATION OF THE PLAN.
(a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than . , have implemented the plan required under this rule.
(b) The Agency shall allow an extension up to . . . . . to providers in compliance with

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A 200	Continued From page 25	A 200		

paragraph (c) below and who can show delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes. Assisted living facilities shall notify the Agency that they will utilize the extension and keep the Agency apprised of progress on a quarterly basis to ensure there are no unnecessary delays. If an assisted living facility can show in its quarterly progress reports that unavoidable delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes will occur beyond the initial extension date, the assisted living facility may request a waiver pursuant to section 120.542, F.S.
(c) During the extension period, an assisted living facility must make arrangements pending full implementation of its plan that provides the residents with an area or areas to congregate that meets the safe indoor air temperature requirements of subsection (1) (a) for a minimum of ninety-six (96) hours.
1. An assisted living facility not located in an evacuation zone must either have an alternative power source onsite or have a contract in place for delivery of an alternative power source and fuel when requested. Within twenty-four (24) hours of the issuance of a state of emergency for an event that may impact primary power delivery for the area of the assisted living facility, it must have the alternative power source and no less than ninety-six (96) hours of fuel stored onsite.
2. An assisted living facility located in an evacuation zone pursuant to chapter 252, F.S. must either:
a. Fully and safely evacuate its residents prior to the arrival of the event; or
b. Have an alternative power source and no less than ninety-six (96) hours of fuel stored onsite,

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A 200	Continued From page 26 within twenty-four (24) hours of the issuance of a state of emergency for the area of the assisted living facility. (d) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (e) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (f) The Agency for Health Care Administration may request cooperation from the State Fire Marshal to conduct inspections to ensure implementation of the plan in compliance with this rule. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration;	A 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964280	A. BUILDING: _____ B. WING _____	07/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 200	Continued From page 27 3. Wellness checks by assisted living facility staff to monitor for signs of , and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration 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. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved	A 200		

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A 200	Continued From page 28 shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on a review of facility records and interviews with the Administrator, the facility failed to develop an emergency environmental control plan (EECP) that included policies and procedures to ensure the effective and immediate activation, operation and maintenance of the alternate power source by facility staff. This had the potential to negatively impact all 43 residents residing in the facility in the event of a power loss and/or generator failure.	A 200		

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A 200	Continued From page 29 The findings include: A review of the facility Comprehensive Emergency Management Plan (CEMP) and supporting documentation was conducted with the Administrator at 3:20 pm on . . . . . . The plan had been updated and implemented by the Administrator on . . . . . Review of the documents found no policies or procedures to address emergency environmental control in the event of the loss of primary electrical power or generator failure. There were no procedures to ensure temperatures inside the facility did not exceed 81 degrees degrees Fahrenheit for 96 hours, or to ensure facility staff could effectively and immediately activate, operate or maintain the generator and fuel required for it's operation. The plan lacked instructions related to the provision of resident care, hydration and wellness checks, the use of cooling devices, refrigeration and freezers for ice and medication storage, or the provision of emergency medical intervention for residents in need in the event of a loss of power. The Administrator looked for additional information after confirming the required information was missing from the plan. He returned at 3:50 pm on . . . . . and reported that was all he had. He acknowledged the importance of policies and procedures that all staff could readily access and implement in the event of emergency. Class III	A 200		