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 |
|---|---|---|---|
| | AL11965159 | A. BUILDING: _____ B. WING _____ | 05/12/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SABAL HOUSE | 150 CROSSVILLE STREET CANTONMENT, FL 32533 |

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| A 000 | Initial Comments<br><br>An unannounced complaint survey (2020008424) was conducted at Sabal House Assisted Living Facility on through . At the time of the survey, deficient practice was identified.<br><br>A class I deficiency was identified on , at A0025, Resident Care and Supervision for the facility's failure to ensure residents at risk for elopement were supervised to prevent them leaving the building unattended. The facility Regional Director of Clinical Services and Executive Director were notified of the Class I deficiency on at 3:15pm. At the time of the survey the facility census was 27. | A 000 | | |
| A 025 SS=J | 429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision<br><br>429.26<br>(7) The facility must notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.<br><br>59A-36.007<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, | A 025 | | |

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| A 025 | Continued From page 1<br><br>including the following:<br>(a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C.<br>(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.<br>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.<br>(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.<br>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to maintain general awareness and whereabouts of 1 of 4 sampled resident's (#1) resulting in an elopement from the facility.<br><br>The facility's failure to properly supervise the resident, based on his elopement risk assessment and observed behaviors, resulted in staff being unaware of the elopement of Resident #1 during the evening of . This failure resulted in a Class I deficiency. The Regional Director of Clinical Services (RDCS), and | A 025 | | |

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| A 025 | Continued From page 2<br><br>Executive Director were notified of the Class I deficiency on at 3:15pm.<br><br>The findings include:<br><br>A record review indicated that resident #1 was admitted on . . . . . , and an elopement risk assessment was conducted on the day of admission. The risk assessment found resident #1 to be at high risk for elopement. Based on this risk assessment the resident was placed on hourly checks.<br><br>A record review was conducted for resident #1 which revealed that on . . . . . at shortly after 9:00PM, the facility received a telephone call from a family member that the resident was found by his spouse at the family home a few minutes earlier at approximately 9:00PM. The resident's family home was about 3.2 miles away, indicating that he had most likely walked the 3.2miles from the facility to the home. The route from the facility to the home involved two heavily trafficked four lane roads that included both construction and crossing an Interstate I-10 exit ramp. No sidewalks existed anywhere along this route.<br><br>On at 4:18PM, an interview was conducted with staff B, a medication technician, who stated that they had worked with the resident since admission and was not informed that the resident was a . The staff member stated that on Resident #1's second day in the facility he "hit every door in this building and set off every alarm, I was running all over. We tried everything, redirection, activities, nothing worked". Staff B further revealed that on the day of the elopement ( ) "it was already a crazy day here" and resident #1 "was doing the same exit seeking behavior". In describing the | A 025 | | |

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| A 025 | Continued From page 3<br><br>events the night the resident eloped, Staff B stated she last saw resident #1 around 6:56PM, in his room with the door open. After that she reported she had gone on a break and came , at around 9:00PM, at which time staff A informed her that resident #1's family called to say he was at the family home. Staff B said she ran to his room and searched whole building, checked all doors, rooms and windows, and could not determine how resident #1 left the building.<br><br>Staff A was unavailable for interview. A statement from staff A, a medication technician, dated , stated staff A got a phone call around 9:20PM, from a family member of resident #1, stating that resident #1 was at the family home.<br><br>On at 4:20 PM a review of the website https://sunrise-sunset.org/Us/Pensacola-fl revealed that sunset on occurred at 7:29pm.<br><br>A review of hourly round sheets for resident #1, indicated hourly rounds were initiated on and were documented as being completed at night between 10:00PM and 5:00AM on , and but were not documented the night of the resident's elopement on . Further review of the documents revealed that no checks were conducted on & .<br><br>On at approximately 1:40PM, an interview was conducted with the Executive Director during which he was asked about missing hourly rounding sheets for , , . The Executive Director responded, "If the sheets aren't there, they weren't done," and confirmed that they had not been pulled for review. | A 025 | | |

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| A 025 | Continued From page 4<br><br>Record reviews were conducted for residents #2, #3, and #4, all identified as requiring hourly checks revealed that all had no documentation of hourly checks for . . . . , . . . . . , and . . . . . .<br><br>On . . . . . at approximately 9:37AM, an interview was conducted with the Resident Care Director (RCD) during which she said that she had educated staff on the need to not just initial the hourly check sheet but to document what resident was actually doing during the check. She further explained that resident #1 was started on hourly checks because of exit seeking behaviors, stating "we knew we needed to have . . . on him all the time", "I can't tell you how many times I have redirected him to the courtyard. I have had a couple of residents who would exit seek for the first week or 2 but not to this degree". She further stated "I suggested to consider a sitter and mentioned this to RDCS, but the family would have to be consulted".<br><br>On at 10:14AM, an interview was conducted with the RDCS, who stated "we need to do additional training with the staff on patient safety and documentation, because the one-hour check sheets are not filled out as well as I would like them". The RDCS further stated in regard to resident #1's elopement, "the shift supervisor should have been monitoring more closely what was happening at that time, because the other 2 staff were on another hall".<br><br>A review conducted of the door alarm report for between 6:56PM and 9:20PM, the times that resident #1 was not observed, revealed that there were no exit door alarms activated.<br><br>On at approximately 2:25PM an | A 025 | | |

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| A 025 | Continued From page 5<br><br>interview was conducted with the RDCS and ED, who agreed the alarm report does not indicate an exit door alarm was activated during the time of resident #1's elopement on . The RDCS stated based on the report he believed the door alarm had been at the time of the elopement of resident #1. The RDCS and ED both agreed that the exit doors would not alarm if they were not reactivated after being opened.<br><br>Class I | A 025 | | |
| A 165 SS=D | 429.23( & ) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report<br><br>429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.-<br>(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.<br>(2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means:<br>(a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in:<br>1. ;<br>2. or , damage;<br>3. Permanent ;<br>4. or of bones or joints;<br>5. Any condition that required medical attention to | A 165 | | |

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| A 165 | Continued From page 6<br><br>which the resident has not given his or her consent, including failure to honor advanced directives;<br>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<br>7. An event that is reported to law enforcement or its personnel for investigation; or<br>(b) Resident elopement, if the elopement places the resident at risk of harm or injury.<br>(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.<br>(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.<br><br>(6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415.<br>(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 | A 165 | | |

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| A 165 | Continued From page 7<br><br>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.<br>(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.<br>(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.<br>(10) The agency may adopt rules necessary to administer this section.<br><br>59A-36.016 Adverse Incident Report.<br>(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.<br>(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. | A 165 | | |

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| A 165 | Continued From page 8<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review, staff interview, and policy review, the facility failed to identify elopement as neglect and to report an elopement to the state agency, the Department of Children and Families, as required under chapter 415, for 1 of 1 resident sampled (#1).<br><br>The findings include:<br><br>Record review indicated that resident #1 was admitted on . . . . . An elopement risk assessment was conducted on the day of admission, and the risk assessment found resident #1 to be at high risk for elopement. Based on this risk assessment the resident was placed on hourly checks.<br><br>A record review was conducted for resident #1 which revealed that on . . . . . at shortly after 9:00PM, the facility received a telephone call from a family member that the resident was found by his spouse at the family home a few minutes earlier at approximately 9:00PM. The resident's family home was about 3.2 miles away, indicating that he had most likely walked the 3.2miles from the facility to the home. The route from the facility to the home involved two heavily trafficked four lane roads that included both construction and crossing an Interstate I-10 exit ramp. No sidewalks existed anywhere along this route.<br><br>On at 4:18PM, an interview was conducted with staff B, a medication technician, who stated that she had worked with the resident since admission and was not informed that the resident was a . The staff member stated that on Resident #1's second day in the facility he "hit every door in this building and set | A 165 | | |

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| A 165 | Continued From page 9<br><br>off every alarm, I was running all over. We tried everything, redirection, activities, nothing worked". Staff B further revealed that on the day of the elopement ( ) "it was already a crazy day here" and resident #1 "was doing the same exit seeking behavior". In describing the events the night the resident eloped, Staff B stated she last saw resident #1 around 6:56PM, in his room with the door open. After that she reported she had gone on a break and came , at around 9:00PM, at which time staff A informed her that resident #1's family called to say he was at the family home. Staff B said she ran to his room and searched the whole building, checked all doors, rooms and windows, and could not determine how resident #1 left the building.<br><br>A review of hourly round sheets for resident #1, indicated hourly rounds were initiated on and were documented as being completed at night between 10:00PM and 5:00AM on , and but were not documented the night of the resident's elopement on . Further review of the documents revealed that no checks were conducted on & .<br><br>On at approximately 1:40 PM, an interview was conducted with the Executive Director (ED) during which he was asked about missing hourly rounding sheets for , , . The Executive Director responded "If the sheets aren't there, they weren't done," and confirmed that they had not been pulled for review.<br><br>On at approximately 11:14AM, the ED stated that the elopement event was not considered as or neglect. But at this time she does think that the policy should have | A 165 | | |

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| A 165 | Continued From page 10<br><br>been considered and it might have changed when they would have initiated the 1:1 policy for resident #1. She was asked if any other agencies should have been notified and said "no", she did not identify any other agency notification that would be required. An adverse incident report was submitted to the state licensing agency, the Agency for Health Care Administration.<br><br>On at 10:14am during an interview with the Regional Director of Clinical Services regarding the elopement of resident #1, he also confirmed stated "No other agencies were notified."<br><br>A review of the policy, titled " policy" with an issue date of , stated prevention of includes assign sufficient staff to meet the needs of the resident and provide staff access to information about specific resident care needs. The policy indicated a requirement for assigned staff to know the whereabouts of each resident during their assigned shift. The policy indicated when appropriate, the ED or designee will notify (d) state licensing and certification agency and (f) adult protective services.<br><br>Class III | A 165 | | |