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 _____	R 08/26/2020

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 A revisit to a complaint survey (compleint # 202001287) and a focused . . . . control surey was conducted at Lakewood Retirement Center on . . . . . . Deficiencies were found to be uncorrected 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 observations, staff interviews and a review of facility records, the facility failed to conduct resident elopement drills for all direct care staff. The findings include:	{A 032}		

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{A 032}	Continued From page 2 In an interview with the Administrator on [redacted] at 10:00 am, she was asked to see evidence that elopement drills were being conducted with all direct care staff. She said she was still coordinating everyone's schedules and had not yet conducted an elopement drill from the time of the last survey to today . She was still working on that. When asked if any of the residents were identified as an elopement risk, she replied maybe Resident 2, because he , but she could think of no others. An observation was conducted of Resident 4 on at 10:35 am. She walked over to approach this writer and hovered very close, without regard to social distancing or personal space. She smiled and said hi, and continued to stare and smile. A staff member intervened and redirected her to another location in the room. Resident 4 was observed to be ambulatory without assistance. She [redacted] around the area without apparent purpose for several minutes, then went to her room. She was observed about the facility on and off on [redacted] between 12:35 pm to 3:00 pm with no apparent destination or purpose. A record review conducted for Resident 4 revealed an AHCA 1823, Resident Health Assessment, that was completed by her health care practitioner on [redacted]. Diagnoses included , and [redacted]. The practitioner noted Resident 4 was and . She required assistance by staff for activities of daily living. The box asking if Resident 4 was at risk for elopement was marked "Yes". An interview was conducted with Employee G, Caregiver on at 12:55 pm. She stated	{A 032}		

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{A 032}	Continued From page 3 she had worked here for a couple of weeks but had not participated in an elopement drill. She did not know of any residents identified at risk for elopement. A review of facility records confirmed there was an elopement policy, but no elopement drills conducted since last survey in . In a second interview with the Administrator on at 1:59 pm, she was advised Resident 4 was identified on her 1823 as at risk for elopement. She stated she was not aware. This was cited by a representative of this agency during a survey conducted on to . Class III	{A 032}		
{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 part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member	{A 161}		

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{A 161}	Continued From page 4 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 ˬ 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 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 a review of facility records and	{A 161}		

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{A 161}	Continued From page 5 interview with the Administrator, the facility failed to maintain the written work schedule for 1 of 4 weeks reviewed. The findings include: Review of the facility schedules from [illegible] to [illegible] found that for the week of [illegible] through [illegible], it was blank for all 7 days on all shifts. There were no staff hours documented for the entire week. Several days did not reflect the 24 hour staffing pattern, as nobody was scheduled to work past 9:00 pm. Photographic evidence obtained. An interview was conducted with the Administrator on at 1:59 pm. She was not able to produce a completed staff schedule for the week of - 16, 2020, and confirmed the omitted week. In a second interview at 3:10 pm, she asked if she could fill that week's schedule out now. This was cited by a representative of this agency during a survey conducted on [illegible] to [illegible] Class III	{A 161}		
{A 193}	59AER20-4 Mandatory Testing for Assisted Living Facilit (1) APPLICABILITY. The requirements of this emergency rule apply to all assisted living	{A 193}		

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{A 193}	Continued From page 6 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, 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 193}		

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{A 193}	Continued From page 7 (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. (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 a review of facility records and interviews with staff, the facility failed to obtain written evidence of negative COVID-19 test results pursuant to Emergency Rule 59AER20-4 "Mandatory Testing for Assisted Living Facility Staff" effective , prior to permitting 9 of 15 staff (Staff J, K, O, P, Q, S, T, U, and V) to enter the facility. This had the potential to place all 11 residents at risk for from SARS-CoV-2, the that causes COVID-19. The findings include: In an interview with the Administrator at 10:10 am on , she said she sent emails to visiting/contract staff for to request COVID-19 test results prior to their entry.	{A 193}		

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{A 193}	Continued From page 8 A review of facility records found a sign-in log to document visits from the facility's staff and service providers from to . The log reflected 15 visiting staff had been to the facility. Review of the COVID-19 lab test results for those staff was conducted, and a comparison made to the sign-in log. Of 15 staff who had signed in, the following did not have documentation of negative COVID-19 status: Staff J, (position unknown) who signed in on . Staff K, Hospice worker, signed in on . Staff O, pharmacist, signed in on . Staff P, plumber, signed in . Staff Q, accountant, signed in . Staff S, plumber, signed in . Staff T, (position unknown), signed in . Staff U, air conditioning repairman, signed in Staff V, air conditioning repairman, signed in An interview was conducted with the Assistant Administrator at 10:45 am on . She was asked to look at the log and verify the names of some of the staff whose signatures were illegible on the signature blocks of the log. Photographic evidence obtained. When asked about Staff P, who signed in on , she said that was a plumber who came in for a few minutes. He verbally indicated his COVID-10 test was negative, but she did not obtain evidence in writing. In a second interview with Assistant Administrator (AA) at 1:50 pm on , she explained that	{A 193}		

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{A 193}	Continued From page 9 Staff O was with the pharmacy. She came in yesterday. Staff O reported she had a negative COVID-19 test, but had not yet emailed her test results to the Administrator. She was not sure about the two air conditioning repairmen. The Administrator would know if they provided their test results. She was shown the COVID-19 test results on file but did not have an explanation as to why there were 9 staff who entered the facility without proof of testing. The AA insisted they tell the staff on entry they are required to provide proof of test results. She was not always here to make sure they provided that documentation. An interview was conducted with the Administrator at 1:59 pm on . She insisted all staff should have their COVID-19 test results before being permitted entry. She was shown the records and confirmed 9 visiting staff did not have documented test results on file. This was cited by a representative of this agency during a focused control survey conducted on to . Class III	{A 193}		