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
	AL11953460	A. BUILDING: _____ B. WING _____	C 12/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DESTIN	2400 CRYSTAL COVE LANE DESTIN, FL 32541

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Biennial Survey, in conjunction with an Extended Congregate Care and Limited Nursing Services Monitoring Visit, a Focused . . . . . Control Survey and a Complaint Survey for allegations set forth in Complaint # 2020015845, was conducted at Brookdale Destin in Miramar Beach, FL from to . . . . . Deficient practice was identified at the time of the survey. Class I deficiencies were identified on at A0025, Resident Care - Supervision for the facility's failure to maintain a general awareness of the resident's whereabouts and A0078 - Staffing standards for the facility's failure to ensure that . . . . . agency staff were qualified to perform their assigned duties by failing to provide education on the facilities policies and procedures related to missing residents, nightly bed checks and courtyard safety guidelines which resulted in Resident #11 being locked out of the building for approximately 16 hours, when the overnight low was 31 degrees Fahrenheit. The resident was found . . . . . the morning of . The facility Administrator and the Corporate Nurse were notified of the Class I deficiency on at 2:20 PM. At the time of the survey the facility census was 89.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall 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	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel 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	A 025		

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A 025	Continued From page 2 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 staff interview, Hospice nurse interview, Law Enforcement interview and record review, the facility failed to appropriately supervise residents by failing to maintain awareness of the resident's whereabouts for 1 of 32 (#11) residents on the Memory Care Unit resulting in the of a resident. The facility's failure to appropriately supervise Resident #11 resulted in staff not being aware that resident #11 was missing until he was found after being locked outside the facility for a period of approximately 16 hours on a night when the temperature dropped to 31 degrees Fahrenheit. This failure resulted in a Class I deficiency. The facility Administrator and the Corporate Nurse were notified of the Class I deficiency on . The findings include: On at approximately 1:24 PM, the Administrator and Corporate nurse reported that on at 6:30 AM, Resident #11 was found in the facility courtyard several . . . from his wheelchair down in the grass. He was . . . . . They further reported that on the night of staff member Q, an agency Licensed Practical Nurse (LPN), had been assigned to work in the Memory Care Unit where resident #11	A 025		

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A 025	Continued From page 3	A 025		

was housed. After the resident had been found Nurse Q, LPN, reported that she had not seen Resident #11 all night, that she had not looked for him nor had she reported the resident missing to anyone.

During the interview, both the Administrator and the Corporate Nurse informed the surveyors that law enforcement was investigating the resident's , and the officer had instructed them that this was a criminal investigation and for that reason they were not permitted to discuss all the details of the case with anyone outside of law enforcement and that they were not allowed to make contact with the alleged , , (Staff Q, LPN) without prior approval from law enforcement. They had also been instructed not to discuss the situation with other staff members as this was an active investigation.

A record review was conducted for resident #11 which revealed he was admitted to the facility on with a diagnosis of 's . He was transferred to the facility's locked memory care unit on after having issues with . Review of the resident's medication observation record (MOR) for the evening of revealed that the resident had received (a medication for 's) 10/100 milligrams (mg) at 2:00 PM. Further review of the MOR revealed that resident #11 had not received his ordered medications at 3:00 PM, 5 PM, 7 PM or 8 PM, as the spaces for the nurse to document the administration of these medications were blank. At 7:00 PM, Agency Nurse Q signed out (a controlled , medication) and , (a controlled medication used to treat and ,) for the resident; however, when reviewing the Medical Record there were no medications documented as given on or after

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A 025	Continued From page 4 this time to resident #11. There was an order on the Medication Record for ( ) readings with parameters for calling a physician each shift. The documentation by nurse Q in this area was, "03," which indicated "Absent from Home." There is no indication in the record of the staff conducting night checks on the resident during Nurse Q's shift, which per review of the time clock records started at 6:00 PM, on . Review of a progress note for resident #11 entered by the Health & Wellness Director and dated at 8:30 AM, stated, "At approximately 6:30AM, resident was found in courtyard by (Facility Aide K). (Aide K) notified Hospice. Upon arrival (Hospice Nurse) pronounced resident's . Per (Hospice Nurse) the police were notified. Per (the Administrator) family was notified." On at 3:18 PM, an interview was conducted with the Hospice Nurse. At that time, she stated that when she received the call that Resident #11 had , she was, "shocked," as she felt his passing was unexpected. She stated that she was warned that the situation on-site was, "unusual." She stated that when she got to the front door of the facility, she could not find anyone so she walked around . She stated that she saw Facility Aide K on the way to Resident #11's room and was informed by Facility Aide K that he was not in the room. She said that Facility Aide K walked her to the door to the secured courtyard and from the door she could see that something was covered with a blanket. She stated that she had Facility Aide K pull the blanket and was then able to see that Resident #11 was lying down and his were completely purple. She said at that	A 025		

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A 025	Continued From page 5 point he was obviously . . . . . so she told everyone to keep away from him, not to touch anything and call Law Enforcement and the facility's Management. When asked how the facility's staff explained what she found she said that she was told that he had been missing the night before, that there was no documentation that the nurse gave him his medication that night. She stated that she also heard that there were 32 residents and one staff member on the unit with them. On . . . . . at 3:47 PM, an interview was conducted with Law Enforcement Investigator T. He stated that he had interviewed Agency Aide U the day before over the phone. He stated that Agency Aide U was told by Agency Nurse Q that she did not need her help on the Memory Care Unit and that Agency Aide U should assist in the Assisted Living section of the building instead. This left Agency Nurse Q in the Memory Care Unit alone with the residents. Agency Aide U stated that she was not made aware that Resident #11 was missing until the morning he was found in the courtyard. Investigator T stated that he spoke to Agency Nurse Q for minutes with the facility Administrator and would be following up with a comprehensive interview with her soon. He stated that Agency Nurse Q, "pre-documented," pulling controlled medications and that they were unable to locate where the medications went because they were not documented as given to Resident #11, only that they were removed from the controlled drug drawer. On . . . . . at approximately 9:44 AM, an interview was conducted with staff member V, a resident assistant, who stated the door leading to the courtyard outside the Memory Care Unit	A 025		

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A 025	Continued From page 6 automatically locks daily between 5:30 and 6:00 PM, and unlocks at 6:00 AM. She stated if the door is locked and someone tries to open it, there is an alarm that sounds. She stated the alarm rings while the door is open and stops when the door is closed. On at 10:54 AM, an interview as conducted with the Administrator during which he stated that the doors to the courtyard are on an automatic timer and lock themselves at 6:00 PM, every night and unlock at 6:00 AM, every morning. A review of the AccuWeather for the night of and morning of revealed that the low was 31 degrees Fahrenheit (retrieved from https://www.accuweather.com/en/us/pensacola/32501/ -weather/328165?year=2020). A review of the, "Missing Resident Policy," effective date: and last Revised: . Under the section titled, "Policy Overview:" it stated, "A missing resident requires immediate associate attention. If associates discover a resident's whereabouts are unknown, associates must immediately begin to follow the procedures of this Missing Resident Policy. A visual (-to-) observation of the missing resident is considered confirmation that the resident has been found." Under the section, "Policy Detail," the policy lays out in number order the following: Follow the steps until the resident is found. 1. Check the sign-in/sign-out book. 2. Conduct thorough interior search of community including, but not limited to, all resident rooms, common areas, closets, stairwells, offices, and restrooms. Consider even small spaces such as	A 025		

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A 025	Continued From page 7 under beds and behind furniture. 3. If found, complete an incident report. If not found, continue to next step. 4. Follow procedure in Missing Resident Response Worksheet. 5. Conduct thorough exterior search of the immediate grounds. Again, consider small, "hiding," spaces such as behind bushes, culverts, etc. 6. If found, complete an Incident Report according to procedure. If nor found, continue to the next step. 7. The supervisor on duty will call the police and contact the Executive Director (ED) or designee. The ED or designee will contact the resident's family or responsible party. 8. When the police department is notified, the supervisor on duty will provide a current picture of the missing resident and description of last known outfit of clothing. 9. The supervisor on duty will complete a Resident Log/Point Click Care (PCC) progress notes entry outlining the events surrounding the missing resident's departure within 24 hours. 10. Consults Reportable Events policy and grid to determine what further actions are required. 11. Within 24 hours of the missing resident/elopement, the ED of designee will notify the appropriate state agency. A review was conducted of the policy titled, "Night Checks Policy - CS-100-16," with an effective date of . . . and last revised on . . . . In the section titled, "Policy Overview," It stated, "Resident care staff should make night check of the residents. A resident of his/her legally responsible party may choose not to have the associates perform night checks. The choice not to receive night checks should be documented in a Negotiated Risk Agreement, where permitted by	A 025		

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A 025	Continued From page 8 state regulation, and on the resident's service plan." Under the, "Policy Detail," section it stated, "1. Associated should perform night checks approximately ever four (4) to six (6) hours or as determined by the residents' need. 2. When performing a night check, associates should open the door to the resident's apartment quietly and observe the resident from a reasonable distance. Assistance should be provided as necessary. 3. For residents who have signed a Negotiated Risk Agreement choosing that night checks not be performed, associates should stop outside the door to the apartment and listen briefly outside the closed door for any unusual sounds. If any unusual sounds, the apartment should be entered, and the resident checked. Associates should document in the Resident Log or PointClickCare (PCC) Progress Notes the reason the room was entered and the outcome." Class I	A 025		
A 078 SS=J	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership.	A 078		

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A 078	Continued From page 9 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing	A 078		

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A 078	Continued From page 10 agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on staff interview, Law Enforcement interview and record reviews, the facility failed to ensure that agency staff were qualified to perform their assigned duties by failing to provide education on the facilities policies and procedures related to missing residents, nightly bed checks and courtyard safety guidelines for 2 of 2 agency staff reviewed (Agency staff Q & U). The facility's failure to properly ensure agency staff were qualified to perform their assigned duties resulted in Agency Nurse Q and Agency Aide U failing to identify a missing resident which resulted in resident #11 being found . . . . . after being locked outside in the secured courtyard for a period of approximately 16 hours on a night when the temperature outside dropped to 31 degrees Fahrenheit. This failure resulted in a Class I deficiency. The facility Administrator and the Corporate Nurse were notified of the Class I deficiency on . The findings include: On a record review was conducted for resident #11 which revealed a progress note entered by the Health & Wellness Director and	A 078		

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A 078	Continued From page 11 dated . . . . . at 8:30 AM, stated, "At approximately 6:30AM, resident was found in courtyard by (Facility Aide K). (Aide K) notified Hospice. Upon arrival (Hospice Nurse) pronounced resident's . . . . . Per (Hospice Nurse) the police were notified. Per (the Administrator) family was notified." Review of the Medication Observation Record (MOR) revealed that the last time the resident had received his medication was noted to be at 2:00 PM, all times (3:00 PM, 5 PM, 7 PM or 8 PM) after this were noted to be blank and the documentation slot for an ordered . . . . . reading had documented "03" which indicated "Absent from home" and was documented by agency nurse Q, an Licensed Practical Nurse (LPN). On at approximately 1:24 PM, the Administrator and Corporate nurse reported that on at 6:30 AM, Resident #11 was found in the facility courtyard several . . . from his wheelchair down in the grass. He was . . . . . They further reported that on the night of staff member Q, LPN, had been assigned to work in the Memory Care Unit where resident #11 was housed. After the resident had been found Nurse Q, LPN, reported that she had not seen Resident #11 all night, that she had not looked for him nor had she reported the resident missing to anyone. On at 3:47 PM, an interview was conducted with Law Enforcement Investigator T. He stated that he had interviewed Agency Aide U the day before over the phone. He stated that Agency Aide U was told by Agency Nurse Q that she did not need her help on the Memory Care Unit and that Agency Aide U should assist in the Assisted Living section of the building instead. This left Agency Nurse Q in the Memory Care	A 078		

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A 078	Continued From page 12 Unit alone with the residents. Agency Aide U stated that she was not made aware that Resident #11 was missing until the morning he was found in the courtyard. A review of the personnel records for the agency staff assigned to work in the memory care unit on the night of revealed that Agency Nurse Q and Agency Aide U had no documentation of receiving in-services or other education related to the facility policies and procedures or resident care. A review was conducted of the, "Agency Orientation Checklist," issued . This form had an area for the staff members name, date and shift worked. The topics covered on the form were /neglect/ , , Resident rights, Current Census and Assignment Plan, Tour of Community, Review of Doors on Memory Care/Assisted Living, Alarm System, Phone System, Internal Floor Codes for Associates Only, Fire System, Emergency Disaster Plan, Injury Policy, Documentation Requirements in PointClickCare (Electronic medical record) and log, care, Change of Condition, Shift to Shift Communication, Missing Resident/Resident Leave of Absence, Incident Reporting and Reportable Events Grid/Who to call in case of emergency. There was an area for both the Staff member giving the orientation and the Agency staff to sign that these topics were covered. The review revealed that this checklist was not completed for Agency staff nurse Q, or agency staff U, a Certified nursing assistant, the only agency staff working in the facility on the night of . On at 10:54 AM, an interview as conducted with the Administrator. He stated that	A 078		

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A 078	Continued From page 13 he was the person that oriented the Agency staff to the floor. He stated that at the start of their shift on ..... he informed them that residents were going to be receiving meals in their rooms and other various tasks that they were to complete for the night. When asked he stated that he did not specifically tell them about the night check policy, the courtyard guidelines or the missing resident policy. He further stated that all of the orientation was verbal and that he did not document any orientation for the Agency staff that worked that night. He also stated that the doors to the courtyard are on an automatic timer and lock themselves at 6:00pm every night and unlock at 6:00am every morning. A review of the AccuWeather for the night of and morning of revealed that the low was 31 degrees Fahrenheit (retrieved from https://www.accuweather.com/en/us/pensacola/32501/ -weather/328165?year=2020). Class I	A 078		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1)Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility	A 081		

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	AL11953460	A. BUILDING: _____ B. WING _____	C 12/29/2020

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A 081	Continued From page 14 must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:	A 081		

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A 081	Continued From page 15 (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs.	A 081		

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A 081	Continued From page 16 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on staff interview and review of personnel records, the facility failed to provide a preservice in-service of at least 2 hours to new employees prior to interacting with residents for 3 of 3 facility employees reviewed (A, B and C). The findings include: A review of the facility staff personnel records revealed that Staff member A, a resident assistant, had a date of hire of . The personnel file did not contain a signed statement by the Administrator that staff A had completed the required two-hour preservice orientation prior to interacting with residents. Review of staff B, Licensed Practical Nurse	A 081		

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A 081	Continued From page 17 (LPN), revealed a date of hire of . . . . . The personnel file did not contain a signed statement by the administrator that staff B had completed the required two-hour preservice orientation prior to interacting with residents. Review of staff C, LPN, revealed a date of hire of . The personnel file did not contain a signed statement by the administrator that staff C had completed the required two-hour preservice orientation prior to interacting with residents. An interview was conducted with the Corporate Nurse on at approximately 1:20 PM. The corporate nurse confirmed there was no signed statement by the administrator in staff A, staff B and staff C's personnel record stating they had completed the required training. Class III	A 081		
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the . . . . are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in	CZ814		

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CZ814	Continued From page 18 status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic , , submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the assisted living facility failed to maintain employment status of all employees within the background screening clearinghouse for 1 of 3 sampled current staff records (Staff C). The findings include: On at approximately 10:29 AM, a review was conducted of the background screening clearinghouse roster. Staff C, a licensed practical nurse who was hired of , was not listed on the roster. On at approximately 1:20 PM, an interview was conducted with the Corporate Nurse who confirmed these findings. Unclassified	CZ814		