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
	AL11932659	A. BUILDING: _____ B. WING _____	C 01/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT A PACIFICA SENIOR LIVING COMMUNIT	3207 NORTH MONROE STREET TALLAHASSEE, FL 32303

(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 On , a complaint investigation for allegations within Complaint #2020020508 was conducted at Woodmont A Pacifica Senior Living Community. A focused control survey was conducted in conjunction. Additional evidence gathering (documentation and interviews) continued offsite through , , . There were deficiencies identified at the time of the visit. The facility census at the time of the survey was 64. The following Class I deficiencies were identified on at: A0025 - Resident Care-Supervision. The facility failed to assign a designated staff to supervise the facility's assisted living unit during the 3rd shift(10pm-6am) on to conduct observations of resident's activities while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the residents which resulted in for 1 of 3 residents that eloped. (resident #2) Resident #2 was found on . The forecasted temperature on the morning of was 29 degrees Fahrenheit. The facility also failed to provide care and services appropriate to meet the needs of residents at risk for elopement for 3 of 3 elopements by not maintaining a general awareness of the resident's whereabouts. (resident #1, #2, #3). A0032- Elopement. The facility failed to follow their elopement policy by failing to immediately search for a resident that was determined to be missing and to document an elopement occurred for 2 of 3 elopements (resident #1 and #3). The	A 000		

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A 000	Continued From page 1 also facility failed to conduct elopement drills pursuant to sections 429.21, F.S. that included all staff for 3 of 3 shifts. The facility Administrator and the Resident Care Director were informed on of Class I deficiencies during the exit conference at approximately 6:30pm.	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 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	A 025		

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A 025	Continued From page 2 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 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 record review, staff interview, and policy review, the facility failed to appropriately supervise residents by failing to maintain awareness of the resident's whereabouts for 3 or 3 sampled residents who were able to exit the facility without staff knowledge, #1, #2 and #3. The facility failed to assign a designated staff to supervise the facility's assisted living unit during the 3rd shift (10pm-6am) on which resulted in resident #2 being found on the facility grounds by Emergency Medical	A 025		

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A 025	Continued From page 3 Services who had arrived to evaluate a different resident. The forecasted temperature for the morning was a low of 29 degrees Fahrenheit. The facility's failure to appropriately supervise residents and maintain awareness of the resident's whereabouts resulted in a Class I deficiency. The facility Administrator and Resident Care Director were notified of the Class I deficiency on . On , the facility had a census of 64 residents. The findings are: Observation of the facility on revealed the facility layout to be 3 floors. A. On the 1st floor, which is the entrance to the facility, there is the Assisted Living Unit on the east side of the building. The Assisted Living Unit is designated for residents that require minimum assistance with activities of daily living and reminders to complete tasks such as baths, grooming, taking medications, etc. Also, on the 1st floor are staff offices, an activity room, common area with television, a dining room for residents on the 1st floor, and the kitchen. B. On the 2nd floor, there is also an Assisted Living Unit. The residents on this unit require the same care as the unit on the 1st floor. There is also the Transition Unit, a secure unit designated for residents who require a higher level of supervision due to memory , and/or exit seeking behaviors. Residents on the Transition Unit require minimum assistance with activities of daily living and reminders to complete tasks such as baths, grooming, taking	A 025		

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A 025	Continued From page 4 medications, etc. C. On the 3rd floor, there is the Memory Care Unit, a secure unit designated for residents who require a higher level of supervision due to memory , and/or exit seeking behaviors. Residents on the Memory Care Unit require total assistance with activities of daily living such as baths, grooming, taking medications, meals, etc. The census on the facility's 3 units on were as follows: Assisted Living Unit=38 Residents Transition Unit=17 Residents Memory Care Unit=9 Resident Resident #2 Review of the medical chart for Resident #2 revealed the resident was admitted to the facility on with diagnoses of , , Right , with removal of , to right upper extremity, , surgery. The record documented that resident #2 required assistance with ambulation, bathing, , self-care, and transferring. Resident #2 was of and and was documented to have physical limitations with extremity . Resident #2 resided on the Assisted Living Unit located on the 2nd floor. The resident's care plan or 1823 form did not indicate the resident was at risk for elopement. There was no documentation within the medical chart regarding resident#2's elopement. On at approximately 3:15pm an interview was conducted with resident #8, roommate and sister for resident #2. Resident #8 could not inform how long the resident was	A 025		

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A 025	Continued From page 5 missing on . . . . When asked if resident #2 ever went outside alone, resident #8 replied, "No, never". When asked if resident #2 ever eloped or went missing and resident #8 replied, "No". Resident #8 became very emotional so the interview was discontinued. On at approximately 3:37pm, during a telephone interview with Staff B, Personal Care Assistant ( ) on 3rd Shift (10:00pm-6:00am), this staff revealed that his shift started at 10:00pm on and ended at 6:00am on . . . . Staff B indicated he was assigned the Assisted Living side, 2nd floor, where Resident #2 resided along with his primary unit, Memory Care on the 3rd floor. He indicated that usually there are 3 staff working the night shift with 1 assigned to each of the 3 units (Memory Care, Transition, and Assisted Living), but on this night there were only 2 staff in the building due to a call-in causing the staff to have to work short. He revealed that he and Staff A, Med Tech/ , decided to split the Assisted Living unit while working their primary assigned units. Staff A was assigned to the Transition unit located on the other side of the 2nd floor and the remaining residents on the Assisted Living Unit on the 1st floor. Staff B indicated he went and forth all night to provide care. He states he last saw resident #2 between 4:30-5:00 AM in her room with her sister (also a resident at the facility). Staff B indicated he left the facility around 6:05am on . . . . . and did not see any residents outside as he left the building through the front door. On at approximately 3:37pm, during a telephone interview with Staff A, Med Tech/ on 3rd Shift (10:00pm-6:00am), revealed she was assigned to work some rooms on the Assisted Living Unit, but that resident #2's room was not in	A 025		

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A 025	Continued From page 6 her assigned rooms. Staff A indicated that she saw resident #2 on at approximately 11:00pm when she was checking on a different resident in the room catty-corner to resident #2's room. She stated the resident was in her room along with her roommate. She states during another check to the same room catty-corner from resident #2's room at approximately 1:30am on she saw the resident again in her room bedroom. On at approximately 10:45am, during an interview with anonymous staff G, this staff revealed that she did not think resident #2 was capable of walking long distances without assistance due to her unsteady gait and inability to walk long distances or downstairs. She indicated the resident used a wheelchair anytime she left her room. On at approximately 6:30pm, during an interview with the Administrator and Resident Care Director, they both confirmed that on the night of resident #2's elopement, there was not a staff assigned to the Assisted Living Unit which is located on the 1st and 2nd Floor of the facility. They indicated that normally there are 3 staff with 1 staff assigned per floor, but on /20 during the 3rd shift there was a call-in. On at approximately 12:45pm, a telephone interview was conducted with the Administrator. During this interview, the administrator revealed that on the night of resident #2's elopement (/20 on 3rd shift) a staff called off causing the staff to have to work with just 2 people. He stated due to it being last minute, they could not find anyone to cover the shift. He stated, "if you are asking if we had everyone that we needed to work the floor that night, the	A 025		

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A 025	Continued From page 7	A 025		

answer would be "no", because I would have loved to have my 3rd person but the building can still be covered with 2 people. Staff should call another unit if they have residents that require 2-person assist by using their walkie talkies to have a staff come from another unit if there isn't a 2nd person assigned to the unit to assist them. The Administrator stated that on the 3rd shift (10pm-6am) on .../20, one staff was expected to be able to go and forth between the 3 floors to provide care. When asked if this left a floor unsupervised and without a staff at any given time, the Administrator confirmed the floors to be unsupervised during the shift. The administrator revealed the facility has 4 cameras in the facility that are working. Those cameras are as follows: 1st floor at front lobby, 1st floor at a side exit, 3rd floor memory care of the common area, and 1 at the nurse's station on the 2nd floor. The camera in the front lobby and the side exit are the only cameras that show an exit out of the building to see who is coming in and who is going out. The administrator was asked if there was any footage showing resident #2 exiting the building, and he indicated there was no footage of resident #2 leaving the building. He stated that initially there was footage that was assumed to be resident #2 but this footage was later determined to be another resident and not resident #2. The administrator reported that there is only one location he can think of where resident #2 could have logically exited the building, and that was the door by the kitchen given the location she was found. The facility uses pagers that alert the facility staff when certain doors open. However, during this interview, the Administrator stated that he was not aware of any data that indicated the door to the kitchen had sent staff an alert.

A phone interview with Staff D, , on at

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A 025	Continued From page 8 approximately 4:14pm, revealed that resident #2 required staff to push her in a wheelchair anytime she left her room. She indicated that the resident used a walker to ambulate around in her room. Staff D indicated that she did think the resident was unable to go outside the facility without supervision due to assistance she needed with ambulation and the fact the resident had periods of "forgetfulness". Staff D indicated that she worked on the 1st shift on along with 3 other staff; there are usually 5 staff assigned but we were short that morning. She indicated that one of the staff included the Resident Care Director (RCD). She indicated that she was not aware of resident #2 missing until she was calling emergency medical services ( ) for an unresponsive resident on the memory care unit located on the 3rd floor. Staff D indicated that when arrived, they informed the RCD that they had found an unresponsive elderly white female outside and asked if someone could come identify the person to determine if she might be a resident of the facility. Staff D states that was her first awareness that a resident was missing, when it was confirmed that the unresponsive resident was resident #2. She indicated that she arrived that morning around 5:45am, but it was dark, and she did not recall seeing anyone. Staff D indicated during shift change report, Staff A did not indicate any concerns with any residents. On at approximately 4:50pm, during a telephone interview with Staff C, a , this staff indicated that she was assigned to the assisted living unit which is located on the 1st and 2nd floors on . She indicated that during shift report the departing staff did not report anyone missing. She stated not long after her shift started, she left her assigned residents to report to the Memory Care Unit on 3rd floor to assist	A 025		

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A 025	Continued From page 9 with an unresponsive resident. Staff C stated that had to be called and it was that informed the staff about the unresponsive person outside believed to be a resident. She indicated that the RCD had confirmed the person's identity to be resident #2. Staff C indicates that resident #2 required a lot of assistance but in recent months had gotten stronger and was able to toilet herself with little to no assistance. She stated that though she could toilet herself she had an unsteady gait causing the resident to use a walker within her room and a wheelchair outside of her room and between floors. Staff C indicated that staffing has been a problem within the last months and that usually there are 5 staff assigned to the 1st and 2nd shifts, but lately there have been 4 staff assigned to work the entire building and at times just 3 staff on those shifts. Staff C indicated that sometimes it is "extremely hard to meet the needs of every resident". On at approximately 5:20pm, a telephone interview was conducted with the RCD who is also a Licensed Practical Nurse (LPN). The RCD revealed that on she was scheduled to work on the floor due to short staffing. She indicated she arrived to the facility around 5:45am, but sat in her car until about 5:55am. This staff indicated that she did not see anyone outside the facility or coming out the front door. She states I spoke to the staff and got report asking about anything that may have happened and the departing shift did not indicate a missing resident. The RCD indicates she was assigned to the transition unit on the 2nd floor and that was she was there until about 6:50am when she received a call from staff on the Memory Care unit (3rd floor) that indicated there was an unresponsive resident. She stated she told staff to call and when arrived, they informed	A 025		

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A 025	Continued From page 10 her that there was an unresponsive person located outside on the facility's grounds. I informed . . . . I was unaware of any resident from the facility missing, but they insisted that I come out and see if I may be able to identify the person. The RCD indicated that she was escorted by law enforcement, which had arrived with . . . , to the area where the unidentified person was located. The RCD stated she confirmed the person to be resident #2 and was instructed by law enforcement not to contact the resident's family as this would be done by them. The RCD stated she could not remember what type of clothing the resident was in because she was in such a . . . . , she stated that she only remembered there to a blue pillow with stars and a walker that resembled items owned by resident #2. The RCD indicated that she never saw providing care to resident #2 and she was covered by a white sheet and pronounced . . . . . at the time she was asked to identify the resident. This staff stated she interviewed the resident's roommate (which is also the resident's sister) but the resident was unable to provide whereabouts or times. Both sisters were reported to be up most of the night according to staff interviews and statements. The RCD states that resident #2 used a walker to ambulate in her room, but beyond the threshold of her door she was always pushed by staff in a wheelchair. The RCD states, "in the 6 months I have been employed I have never seen the resident walk outside her room." She indicated that resident #2 had a very unsteady gait and was unable to walk long distances. The RCD confirmed there to be only 2 staff working on the 3rd shift starting on . . . . . - . . . . . because there was a last-minute call in, indicating there are normally 3 staff assigned, one per floor.	A 025		

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A 025	Continued From page 11 Review of the facility's adverse incident and initial investigation report revealed resident #2 eloped early morning on . . . . . The time of elopement is still unknown but is believed to have been between 4:30am-7:00am. There was initial footage on facility camera's that was believed to be resident #2 but during an interview on . . . . with the administrator at approximately 11:45am, he indicated that footage was not resident #2. Review of facility records and resident #2's medical record revealed there to be no progress notes or documentation of rounds to ensure resident #2 was accounted for on the 3rd shift from . . . . . /20. Resident #3 A Medical Record review for Resident #3 revealed the resident was admitted . . . . . Resident #3's care plan (effective date of . . . . .) listed the resident as an exit seeker. Resident #3 was also listed on a document provided by facility management during survey as an elopement risk. There was no documentation of resident #3's elopement in the medical record or facility records. Review of hospital records obtained for Resident #3 revealed on . . . . . at 8:14 AM, the resident was brought to the emergency department via emergency medical services after being found walking along the highway with . . . . . to his . . . . The resident said he tripped. The hospital records documented that the facility reported to Law Enforcement that the resident was missing. Resident #3 received suture repair to his . . . . (2 cm length superficial of left temple), suture repair of left upper , (2 cm length and superficial in depth) and suture repair of right (3 cm in length and	A 025		

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A 025	Continued From page 12 . . . . . depth). Resident #1 was discharged to the facility with discharge instructions. Review of facility records and resident #3's medical record revealed there to be no progress notes or documentation of rounds to ensure the resident was accounted for prior to his elopement. On at 11:46am, a telephone interview was conducted with anonymous staff H, who confirmed resident #3 had eloped. Staff H revealed resident #3 had eloped about days after the resident's admission to the facility by climbing over a fence after climbing out of his room window. She revealed she recalled staff were asked to get in their vehicles and go and search Monroe Street for resident #3 but were unable to locate the resident. On at 12:45pm, a telephone interview was conducted with the Administrator. The Administrator confirmed resident #3 had eloped sometime in . . . . . but was unable to provide a specific date during this interview. He revealed the resident had crawled out of his window and climbed over a fence on the backside of the facility. He indicated the resident had to be taken for treatment at a local hospital once found due to some minor injuries. The Administrator confirmed he had not submitted an adverse incident or completed and investigation for resident#3's elopement. Resident #1 Review of the medical record for Resident #1 revealed was admitted on . Resident #1 resides on the Transition Unit, a secured unit dedicated to caring for residents who require a	A 025		

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WOODMONT A PACIFICA SENIOR LIVING COMMUNIT	3207 NORTH MONROE STREET TALLAHASSEE, FL 32303

(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 025	Continued From page 13 higher level of supervision due to memory , and/or exit seeking behaviors. Review of Resident #1's care plan dated revealed the resident demonstrates exit seeking behaviors. Interventions include, but are not limited to, training staff in redirection activities that are useful for this resident and notifying the medical doctor, family and Administrator of exit seeking and possible need for more secured unit. Ensure all doors are secured. A review of an adverse incident report (#543552) and facility investigation report was conducted. The investigation documents that on , staff I noticed the resident #1 was not present for dinner (4:30pm-5:30pm) but did not initiate a search for resident #1 at that time, nor did she alert other staff. Law enforcement contacted the facility some time after 5:00pm (exact time not documented) to inform the facility staff of the resident's whereabouts. On at approximately 1:30pm interview with the Resident Care Director revealed that on , the day resident #1 eloped, she had last seen the resident at approximately at 3:00pm sitting on the couch holding a female resident's in the TV Room on the transition unit, 2nd floor. According to review of a police report filed for resident #1's elopement, the resident was 4 miles away from the facility at the Greyhound Bus Station located at 112 west Tennessee Street, Tallahassee, Florida, on at 4:01pm. The report revealed that resident #1 had been picked up by a couple traveling south on North Monroe on , when he was observed to be hitchhiking. The couple advised they pulled over because they were concerned of resident #1's	A 025		

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A 025	Continued From page 14	A 025		

wellbeing. Resident #1 told the couple he was trying to get to St. Petersburg to visit his mom, so the couple offered to give him a ride to the bus station. While traveling to the bus station it appeared Resident #1 possibly had . . . . . because his story wasn't adding up being, he did not have any clothes with him. Concerned for the resident's safety, the couple requested Law Enforcement because they were concerned for his safety. The officer made contact with Resident #1 and the resident was unable to provide information about where he was coming from or traveling to. Resident #1 did not have any luggage or identification on him. Resident was able to provide his name, date of birth, and social security number, but could not provide his address. Resident #1 was free of injury. After further investigation, the officer was able to locate a niece for the resident that informed the officer of the resident's address at the facility.

An interview with resident #1 on at approximately 12:10pm was conducted and the resident's memory appeared to be , . The resident was unable to answer questions about his elopement on . Resident #1 was asked if he had ever left the facility without telling staff and the resident replied, "No".

An interview was conducted with resident #1's guardian on . . . . . at approximately 10:43am. The guardian informed her sister, co-guardian had visited the resident the day he eloped between 10:00am-11:00am. The resident's guardian revealed the resident had a history of elopement prior to being admitted to the facility and that was the reason for the resident being admitted to this facility because he needed to be on a more secure unit. The guardian indicated the resident requires supervision to sign out and the

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A 025	Continued From page 15 resident would not be deemed safe to cross the street without supervision or assistance due to his memory. On at approximately 12:45pm during an interview with the Administrator, he indicated that resident #1 was not captured on any of the facility's cameras leaving the building on . He indicated that it is believed that resident #1 exited the building through a door near the kitchen (the same exit as resident #2). The exit door near the kitchen does not have a working camera. The administrator was asked how staff ensure residents whereabouts and if the facility had a procedure on how often staff should complete those rounds and the Administrator stated he had discontinued 2-hour checks because he did not want families holding him to that timeframe if something happened and staff could not for whatever reason complete the 2-hour checks. The administrator revealed staff do not document resident whereabouts or that they have completed rounds. He indicated that staff were only expected to document if there was a concern with a resident during their shift. Review of facility records and resident #1's medical record, there were no progress notes or documentation of rounds to ensure resident #1 was accounted for on . On at approximately 1:30pm, an interview was conducted with the Resident Care Director (RCD). The RCD revealed she did not think resident #1 could safely cross the road and distinguish between safe and unsafe situations as his short-term memory was . On at approximately 10:35am, an interview anonymous staff G was conducted. The staff	A 025		

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A 025	Continued From page 16 revealed she did not think resident #1 was able to cross the street without assistance or supervision, because he had , . . . memory. "He forgets things a lot, he would definitely be taking a chance by crossing the street." Review of the facility's Elopement policy (policy date) reveals Elopement precautions are carried out for residents who have demonstrated previous attempts to elope or have a history of elopement. The policy states but not limited to the following: 2. 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 .... Review of the facility's policy and procedure titled: "GP 25- Staffing, First Aid, and . " (policy date) reveals The Executive Director is responsible to ensure properly trained staff are available to respond to emergencies and ensure the necessary care and supervision to residents ..... The policy states but not limited to the following: 1. Each community is to provide for a sufficient number of staff to: a. Provide care required in each resident's written record of care b. Ensure the health, and safety, comfort, and supervision of the residents c. Ensure that the Community is clean, safe, sanitary, and in good repair at all times. The facility did not provide a policy upon request regarding how often staff should check on residents' whereabouts. Class I	A 025		

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A 032	Continued From page 17	A 032		
A 032 SS=J	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 18 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 record review, staff interview, and policy review, the facility failed to routinely account for resident whereabouts resulting in the facility being unaware that resident #1 eloped. The facility failed to follow their elopement policy to document an elopement occurred for 2 of 3 elopements (resident #1 and #3). The facility also failed to conduct elopement drills that included all staff for 3 of 3 shifts. The facility's failure to routinely account for resident whereabouts resulted in the facility being unaware that resident #1 elopement resulting in a	A 032		

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A 032	Continued From page 19 Class I deficiency. The facility Administrator and Resident Care Director were notified of the Class I deficiency on . On , the facility had a census of 64. The findings include: Review of the facility's Elopement Policy (policy date) revealed elopement precautions are carried out for residents who have demonstrated previous attempts to elope or have a history of elopement. The policy states, but not limited to, the following: 8. Should an elopement occur; an immediate systematic search of the property and surrounding neighborhood will take place. The responsible party shall be notified. a. Law Enforcement authorities will be notified of elopement within 30 minutes should the resident not be located. b. Once the resident is located, the resident's family/responsible party shall be notified, and the resident shall receive a physical examination and physician consult. c. The elopement will be documented. d. The resident will be reevaluated to determine if the resident is appropriate to be retained in the Community, and if so, Service Plan adjustments should be immediately undertaken to prevent further elopements. The facility is located at 3207 North Monroe Street, Tallahassee, Florida. Interstate 10 is less than a mile away from the facility. Resident #1 Resident #1 is a , white male that was admitted on . Resident #1 resides on the Transition Unit, a secured unit dedicated to	A 032		

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caring for residents who require a higher level of supervision due to memory , and/or exit seeking behaviors. Review of Resident #1's care plan dated revealed the resident demonstrates exit seeking behaviors. Interventions include, but are not limited to, training staff in redirection activities that are useful for this resident and notifying the medical doctor, family and Administrator of exit seeking and possible need for more secured unit. Ensure all doors are secured.

Review of Resident #1's 1823 form dated revealed the resident was not an elopement risk. Resident #1 has a diagnosis of major ( ) and . Resident #1 is hard of hearing and has mild . Resident #1 is documented to be a risk.

Review of an adverse incident and investigation for Resident #1 revealed, the resident eloped on sometime between 3:00 PM to 4:00 PM. Review of the investigation documents that Staff I first noticed the resident was missing when he was not present for dinner, but did not initiate a search at that time, nor did she alert other staff. Facility staff were not aware that Resident #1 had eloped until they were contacted by Law Enforcement at approximately 5:00 PM.

According to review of a police report filed for Resident #1's elopement, the resident was found 4 miles away from the facility at the Greyhound Bus Station located at 112 West Tennessee Street, Tallahassee, Florida, on . The report also revealed that Resident #1 had been picked up by a couple traveling south on North Monroe on , when he was observed to be hitchhiking. The couple reported they pulled

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A 032	Continued From page 21 over because they were concerned for Resident #1's wellbeing. Resident #1 told the couple he was trying to get to St. Petersburg to visit his mom, so the couple offered to give him a ride to the bus station. While traveling to the bus station it appeared Resident #1 possibly had because his story wasn't adding up as he was not observed to have any clothes with him. Concerned for the resident's safety, the couple requested the assistance of Law Enforcement. The officer made contact with Resident #1 and the resident was unable to provide information about where he was coming from or where he was headed. Resident #1 did not have any luggage or identification on him. Resident #1 was able to provide his name, date of birth, and social security number, but could not provide his address. Resident #1 was free of injury. After further investigation, the officer was able to locate a niece for the resident who provided information regarding the facility's address. An interview with resident #1 on [redacted] at approximately 12:10pm was conducted and the resident's memory appeared to be [redacted]. The resident was unable to answer questions about his elopement on [redacted]. Resident #1 was asked if he had ever left the facility without telling staff and the resident replied, "No". On [redacted] at approximately 10:43 AM, an interview was conducted with Resident #1's guardian. The guardian revealed the resident had a history of elopement prior to being admitted to the facility. The guardian continued that the need for a more secure unit, a transitional unit, was the basis for his admission to the facility. The guardian indicated the resident requires supervision to sign out and it would not be safe for him to cross the street without supervision or	A 032		

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A 032	Continued From page 22 assistance due to his memory . Interview with the Administrator on at approximately 12:15pm revealed resident #1 was not captured on any of the facility's cameras leaving the building on . He indicated that it is believed that resident #1 exited the building through a door near the kitchen. The exit door near the kitchen does not have a working camera. The administrator was asked how staff ensure residents whereabouts and if the facility had a procedure on how often staff should complete those rounds, and the Administrator stated he had discontinued 2-hour checks because he did not want families holding him to that timeframe if something happened and staff could not for whatever reason complete the 2-hour checks. The administrator revealed staff do not document resident whereabouts or that they have completed rounds. He indicated that staff were only expected to document if there was a concern with a resident during their shift. The Administrator revealed that Staff I was terminated for not following the facility's elopement policy on by not initiating a search of the facility and outside parameters when she discovered the resident was not present for dinner. The facility conducted an in-service following resident #1's elopement on and updated the resident's care plan effective . The administrator confirmed aside from re-inservicing staff, the facility had not put into place any interventions in between resident #1's elopement and resident #2's elopement. Resident #3 On , at approximately 9:00am, during the entrance conference with facility management staff (Resident Care Director and the Memory Care Director), this surveyor requested a copy of	A 032		

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adverse incidents that had been submitted within the last year. At that time, this surveyor also requested a list of residents that had eloped along with any investigations that had been conducted.

Following the entrance, on [redacted] at approximately 11:15 AM, the Administrator provided 2 adverse incidents with investigations for Resident #1 and Resident #2. At that time, the Administrator confirmed these were the only incidents that had occurred in the facility within a year.

On [redacted] at approximately 10:35 AM, a telephone interview was conducted with anonymous Staff G. Anonymous Staff G stated there had been 3 elopements at the facility within the last year. She revealed that Resident #1, Resident #2, and Resident #3 had eloped. This surveyor asked anonymous Staff G to provide further details about Resident #3's elopement and the staff stated the resident had eloped about [redacted] months before Resident #1 who eloped on [redacted]. Anonymous Staff G stated that it is believed Resident #3 was found near Interstate-10 walking.

On [redacted] at 11:46 AM, a telephone interview was conducted with anonymous Staff H who confirmed that Resident #3 had eloped. Staff H revealed Resident #3 had eloped about [redacted] days after the resident's admission to the facility by climbing over a fence after climbing out of his bedroom window. She stated that she recalled staff being asked to get in their vehicles and search Monroe Street for Resident #3 (the main road the facility is located off), but were unable to locate the resident.

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A 032	Continued From page 24 On . . . . . at 12:45 PM, a telephone interview was conducted with the Administrator. The Administrator was asked if, in addition to the adverse incidents provided on for Resident #1 and Resident #2, there had been any other resident incidents within the last year that required submission of an adverse incident to the Agency and he replied, "No". This surveyor then asked if Resident #3 had ever eloped and the Administrator paused for several seconds before eventually responding, "I think I recall something like that". The Administrator confirmed Resident #3 had eloped sometime in . . . . . but was unable to provide a specific date during this interview. He indicated the resident had to be taken for treatment at a local hospital once found due to some minor injuries. The Administrator confirmed he had not submitted an adverse incident for Resident #3's elopement. The Administrator stated although he had not completed an adverse incident, the facility did install locks on the windows and enforce the fence by putting a higher fence in the area that Resident #3 was believed to have climbed over. A Medical Record review for Resident #3 revealed the resident was admitted . . . . . Resident #3's care plan (effective date of . . . . .) listed the resident as an exit seeker. Resident #3 was also listed on a document provided by facility management during survey as an elopement risk. There was no documentation of resident #3's elopement in the medical record or facility records. Review of hospital records obtained for Resident #3 revealed on . . . . . at 8:14 AM, the resident was brought to the emergency department via emergency medical services after being found walking along the highway with	A 032		

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A 032	Continued From page 25 . . . . . to his . . . . The resident said he tripped. The hospital records documented that the facility reported to Law Enforcement that the resident was missing. Resident #3 received suture repair to his . . . (2 cm length superficial of left temple), suture repair of left upper , (2 cm length and superficial in depth) and suture repair of right (3 cm in length and . . . . . depth). Resident #3 was discharged to the facility with discharge instructions. Elopement drills Review of facility records, medical records, and staff interviews revealed the facility has had 3 elopements within the last year. Resident #1 eloped on . Resident was returned by Law Enforcement without injury. Resident #2 eloped on . Resident was found . . . . . on facility premises. Resident #3 eloped on . Resident was found by Law Enforcement and treated at local emergency room for minor injuries. On at approximately 9:00 AM, during the entrance conference with the Resident Care Director (RCD) and the Memory Care Director, this writer requested elopement trainings and elopement drills conducted within the last year for review. The facility provided documentation of elopement in-services during the onsite visit on , but none of the information provided detailed that a drill had been conducted. The facility's policy refers to elopement drill records, but these have not been provided. The trainings were as follows: A. On , , there was a meeting	A 032		

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	AL11932659	A. BUILDING: _____ B. WING _____	C 01/06/2021

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A 032	Continued From page 26 agenda and the training timeframe was for 30 minutes. There was a meeting agenda and topics discussed included: "resident elopement, staff response to missing resident, room to room check, perimeter check, contact police, notify family, resident found, treated for injuries, return to community, increased security measures". The in-service topic read "elopement resident #10". This was confirmed to be Resident #3 by the Resident Care Director. The elopement policy was also attached to the in-service. There was no evidence of an elopement drill being conducted on this date. B. On [redacted], there was a meeting agenda and the training timeframe was for 30 minutes. There was a meeting agenda and topics discussed included: "resident elopement, staff response to missing resident, room to room check, perimeter check, contact police, notify family, resident found, treated for injuries, return to community, increased security measures". The in-service topic was blank. The elopement policy was also attached to the in-service. There was no evidence of an elopement drill being conducted on this date. There is no distinction except for the in-service topics. Both trainings' agenda and documentation were similar. On [redacted] at approximately 12:15 PM, an interview was conducted with the Administrator regarding elopement drills. The Administrator revealed that elopement drills are conducted once a quarter for all staff. He stated that most drills have been completed during "admin hours" (8 AM - 5 PM), but there have been drills conducted across all shifts. The Administrator stated the last drill was in [redacted]. He stated there was an in-service following Resident	A 032		

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A	Continued From page 27	A 032		

#1's elopement on . . . . . At that time, evidence of elopement drills that had been completed within the year was again requested by this writer.

On at 3:37 PM, a telephone interview was conducted with Staff B. The interview revealed that Staff B works the 3rd shift as a Personal Care Assistant. Staff B confirmed to have had elopement training but stated there had not been any participation elopement drills. Staff B has worked at the facility for approximately 5 months.

On . . . . . at approximately 10:40 AM, a telephone interview was conducted with anonymous Staff G. The interview revealed she received elopement training, but never participated in an elopement drill. Anonymous Staff G indicated to have worked at the facility for a little over a year. Anonymous Staff G also indicated that when facility management gives training, "they simply . . . us a paper to read and say sign saying you read it". This staff indicated that it's up to staff to read the training, and stated that some staff read it while others just sign their name on the sign-in sheet.

On . . . . . at approximately 11:45 AM, a telephone interview was conducted with anonymous Staff H. The interview revealed she's worked at the facility for 4 months. Anonymous Staff H revealed she recalled attending an elopement training in , but prior to that she had never had any training on elopement or participated in any drills. Anonymous Staff H revealed she worked day shift.

On at approximately 12:45 PM, a telephone interview was conducted with the

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A 032	Continued From page 28 Administrator. This surveyor made an additional request for elopement drills and elopement trainings. The Administrator emailed the trainings listed above again. No additional documentation was provided. On . . . . . at approximately 4:49 PM, a telephone interview was conducted with anonymous Staff C. Anonymous Staff C stated that she has worked at the facility for about 2 years. She stated she normally works the 2nd shift but has worked both 1st and 3rd shifts when needed, which is, "quite often". Anonymous Staff C stated she had elopement training on the computer about 3 months ago but never participated in a drill during her time working at the facility. On . . . . . at approximately 5:18 PM, a telephone interview was conducted with the Resident Care Director (RCD). The RCD indicated that elopement trainings conducted initially are taken on the computer by all staff within their first 30 days of employment. She stated that if there is an elopement there are sometimes refresher trainings. She stated that in-person trainings and drills are completed by the Administrator or by herself. She indicated she had been trained on elopements and that she has participated in drills. She stated that drills are mainly held on 1st shift by conducting mock elopements and designating residents to be found. The RCD indicated drills she had participated in were on 1st shift and was not aware of any drills completed outside those hours during her -month employment with the facility. The RCD was asked what the refresher trainings that follow elopements usually entail. She stated that she reiterates the policy and procedure, though she doesn't usually discuss	A 032		

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A 032	Continued From page 29 the elopement, as most staff are already aware. She further stated that she also answers any questions staff may have. The RCD was unable to provide documentation of the elopement drills. Review of the facility's Elopement Policy (policy date .....) revealed (10) Elopement drills should be conducted in both Assisted Living and Memory Care areas once every six months and documented on the Elopement Drill Record. Class I	A 032		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints;	A 165		

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A 165	Continued From page 30 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency ' s online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency ' s online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident. (6) [illegible], neglect, or [illegible] must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially	A 165		

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A 165	Continued From page 31 involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be	A 165		

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A 165	Continued From page 32 submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on facility record review, staff interview, and review of the Agency's Adverse Incident System, the facility failed to submit or failed to timely submit adverse incident reports for 3 of 4 residents sampled (Resident #1, #3 and #7). The facility failed to submit and adverse incident report for elopement within 1 business day for Resident #1. The facility failed to submit and adverse incident report for elopement Resident #3 and and a [redacted] with hospitalization for Resident #7. The findings include: On [redacted], during the entrance conference with facility management staff (Resident Care Director and the Memory Care Director), this surveyor requested a copy of adverse incidents that had been submitted within the last year. At that time, this surveyor also requested a list of residents that had eloped along with any investigations that had been conducted. On [redacted] at approximately 11:15 AM, the Administrator provided 2 adverse incidents with investigations for Resident #1 and Resident #2. At that time, the Administrator confirmed the these were the only incidents that had occurred in the facility within a year that required an adverse incident to be submitted. Resident #1 Review of the adverse incident (Report #543552) for Resident #1 revealed the resident eloped on	A 165		

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A 165	Continued From page 33 . . . . . The adverse incident had a submission date of . On at approximately 12:15 PM, a follow-up interview was conducted with the Administrator regarding the adverse incident for Resident #1. The Administrator stated he was unable to submit an adverse incident for the elopement of Resident #1 within 1 day because he was out of town. He stated that he was the only staff that could submit an adverse incident and did not have a designee in his absence to do so. Resident #3 On at approximately 10:35 AM, a phone interview was conducted with anonymous Staff G. Anonymous Staff G stated there had been 3 elopements at the facility within the last year. She revealed that Resident #1, Resident #2, and Resident #3 had eloped. This surveyor asked anonymous Staff G to provide further details about Resident #3's elopement and the staff stated the resident had eloped about months before Resident #1 who eloped on . . . . . Anonymous Staff G stated that it is believed Resident #3 was found near Interstate - 10 walking. On at 11:46 AM, a phone interview was conducted with anonymous Staff H who confirmed Resident #3 had eloped. Staff H revealed Resident #3 had eloped about . days after the resident's admission to the facility by climbing over a fence after climbing out of his bedroom window. She stated that she recalled staff being asked to get in their vehicles and search Monroe Street (the main road the facility is located off) for Resident #3, but were unable to locate the resident.	A 165		

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A 165	Continued From page 34 On at 12:45 PM, a phone interview was conducted with the Administrator. The Administrator was asked if, in addition to the adverse incidents provided on for Resident #1 and Resident #2, there had there been any other resident incidents within the last year that required submission of an adverse incident to the Agency and he replied, "No". This surveyor then asked if Resident #3 had ever eloped and the Administrator paused for several seconds before eventually responding, "I think I recall something like that". The Administrator confirmed Resident #3 had eloped sometime in but was unable to provide a specific date during this interview. He indicated the resident had to be taken for treatment at a local hospital once found due to some minor injuries. The Administrator confirmed he had not submitted an adverse incident for Resident #3's elopement. Review of hospital records obtained for Resident #3 revealed on at 8:14 AM, the resident was presented to the emergency department via emergency medical services after being found walking along the highway with to his . The resident said he tripped. The hospital records reveal that the facility reported to Law Enforcement that the resident was missing. Resident #3 received suture repair to his (2 cm length superficial of left temple), suture repair of left upper , (2 cm length and superficial in depth) and suture repair of right (3 cm in length and depth). Resident #3 was discharged to the facility with discharge instructions. Resident #7	A 165		

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A 165	Continued From page 35 On . . . . . at approximately 10:35 AM, a phone interview was conducted with anonymous Staff G. Anonymous Staff G also revealed that Resident #7 had a in early in which the resident . . . . . her , . On . . . . . at approximately 12:45 PM, a phone interview was conducted with the Administrator. The Administrator was asked if, aside from the 3 elopements with Resident #1, #2, and #3, there had been any other incidents in the building that required an adverse incident to be submitted. The Administrator replied, "Not that I am aware of". The regulation for A0165 was read to the Administrator and he was again asked if there had been any other events that required the submission of an adverse incident, he replied, "No not to my knowledge". He was then asked about Resident #7's whereabouts and he indicated the resident was at a rehabilitation center in the Tallahassee area due to a . . . . . , . When asked how the occurred the Administrator stated, "from what I can remember, I believe another resident bumped into Resident #7 causing her to . ". When asked if there was an adverse incident submitted for Resident #7 regarding her . . . . . the Administrator stated he did not complete an adverse incident because there was no physical altercation between the 2 residents, Resident #7 was bumped and to the floor causing the . . . . . A request was made for the Adverse Incident Policy, but has not been provided at the completion of this report Class III	A 165		