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
	AL11964948	A. BUILDING: _____ B. WING _____	01/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DR PHILLIPS MC	8015 PIN OAK DR. ORLANDO, FL 32819

(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 Complaint Investigation #20200017291, Control and Generator monitoring surveys were conducted on . Brookdale Dr Phillips Memory Care had deficiencies at the time of the visit.	A 000		
A 025 SS=G	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 supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	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 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 facility adverse incident report, police call log report and interview, the facility failed to provide adequate supervision and general awareness of whereabouts for 1 of 3 sampled residents who eloped from the secured memory care building (#2). Findings: Review of the facility's adverse incident report with the incident date of [redacted] noted that around 6:39 PM, a call was received from a caregiver who stated that resident #2 could not be found in the memory care building. Resident	A 025		

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A	Continued From page 2 #2 was last seen in the common area at approximately 6:15 PM. The caregiver noticed that he was no longer in the common area. At approximately 6:51 PM on . . . . . , the officer manager arrived to inform them that the resident was found at the bank down the street from the facility. A staff member drove to the location to identify the resident at 6:53 PM on . Resident #2 had complaints of , . . ; emergency medical services (. .) was called. Resident #2's vital signs were within normal limits, and he refused to go to the hospital, so he was released to staff and brought . . . to the facility at 7:05 PM on . . . . . . All administration was advised that resident #2 was safely in the building. On to one (1:1) observation was initiated. Analysis of the Incident (Apparent Causes) revealed that resident #2 was able to hold down the alarmed door until it unlocked. Corrective Action Summary (Corrective or Proactive Actions Taken) revealed that there is now an extra alarm added to the first door of the exit hallway. If the first door is opened, it will alarm very loud to alert staff that the door has been opened. Observations on at 10 AM in the secured memory care unit, resident #2 sat in the common area. An interview was attempted with the resident and he was pleasantly . . . . . The resident did not recall leaving the building and said that he worked at the facility for the government. Resident #2 record revealed he was admitted into the facility on . . . . . Resident health assessment form 1823, dated , noted	A 025		

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A 025	Continued From page 3 "agitation in . . . . . " and that he had memory , . An updated resident health assessment form 1823, dated . . . . . , noted the resident had , was oriented to self with . . . . , and was an elopement risk. Facility notes documented the following: at 6:13 PM - "Resident is alert and awake oriented x 2. High elopement risk. Resident exit the building from D hall around 11:45 AM and opened the 2nd exit door on A hall less than an hour. Resident redirected to his room by staff." at 12:36 PM - "Resident not staying in his room, using a mask when out but sometimes, took it off. Resident is exit seeking, trying to get out of exit doors. Today he packed all his clothes and said, he wanted to go to a greyhound bus to go home. Resident redirected and was explained that his new home is here." . . . . . - "Resident not compliant, this morning tried to leave the building twice. His first attempt was at the front door at 8:57 AM, and at 9:20 AM, tried to exit from D hallway. Resident redirected to his room. He wanted to get a bus to leave Orlando, he said." . . . . . late entry - "A staff received all at 6:39 PM from a caregiver who stated that resident #2 could not be found in memory care building. The staff could not find resident, so a nurse called 911. Resident was last seen in the common area at approximately 6:15 PM. The caregiver noticed that he was no longer in the common area at 6:30 PM. The assistant administrator spoke with the Sheriff deputy who responded to the initial call when she arrived, who informed her that Resident #2 had been found at...Bank...Blvd Orlando at approximately 6:51 PM." The assistant administrator then drove to the location to identify resident #2 at 6:53. Resident #2 had complaints	A 025		

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A 025	Continued From page 4 of . . . , . , so . . . was called. Resident #2's vital signs were within normal limits and he refused to go to the hospital. So, he was released to the assistant administrator to be brought . . . .at 7:05 PM. All administration was updated and advised that resident #2 was safely . . . in the building; 1:1 was initiated. - "Resident still trying to leave the building-one attempt today on d hall." Review of the police call log revealed the sheriff was called on at 6:35 PM regarding resident #2 missing; at 6:45 PM, the resident was found down the street at a bank nearby the facility. Resident #2 was a new admission and was exit-seeking when he arrived. There was no documentation found in the record to confirm what interventions were in place to ensure the resident would not exit the building. The resident exited the secured memory care building and walked to the bank that was 0.7 miles away from the facility at night and was found by the sheriff 's department. The health and wellness coordinator said on at 12 PM, there were two exit doors down the hall where resident #2 resides. She said when the first door opened, the alarm was supposed to sound. She felt the battery was low and it did not alarm loud. She said the second door had a timer on it and if held for 15 seconds it would open. The resident was able to hold the door down without the alarm sounding. She said after checking the door, they later found the magnetic lock was not working but it has since been repaired. She said they now have a special key that would be required to unlock the second door.	A 025		

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A 025	Continued From page 5 On at 12:30 PM, the administrator confirmed the findings, and said the resident should not have been able to leave the secured building. Class II	A 025		
A 032 SS=D	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.	A 032		

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A 032	Continued From page 6 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 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 observation, interview and record review, the facility failed to follow their elopement policy to ensure that 2 of 2 sampled residents at risk of elopement, had identification on their person that included name, the facility's name,	A 032		

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A 032	Continued From page 7 address and telephone number (#1 & 2). Findings: 1. Review of the facility's adverse incident report with the incident date of noted that around 6:39 PM, a call was received from a caregiver, who stated that resident #2 could not be found in the memory care building. Resident #2 was last seen in the common area at approximately 6:15 PM on . The caregiver noticed that he was no longer in the common area. At approximately 6:51 PM, a law enforcement officer arrived to inform the facility staff that the resident was found at the bank down the street from the facility. A staff member drove to the location to identify the resident at 6:53 PM. Resident #2 had complaints of , ; was called. Resident #2's vitals were within normal limits and he refused to go to the hospital, so he was released to staff and brought to the facility at 7:05 PM. All administrative staff was updated and advised that resident #2 was safely in the building. 1:1 observation was initiated. Analysis of the Incident (Apparent Cause) revealed that resident #2 was able to hold down the alarmed door until it unlocks. Corrective Action Summary (Corrective or Proactive Actions Taken) revealed that there is now an extra alarm added to the first door of the exit hallway. If the first door is opened, it will alarm very loud to alert staff that the door has been opened. Observations of resident #2 on at approximately 10 AM revealed he did not have any type of identification on his person. He had	A 032		

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A 032	Continued From page 8 previously left the building on [redacted] without the staff knowledge and was found down the street at a bank. Resident #2's record revealed an updated resident health assessment form 1823 dated [redacted] that noted the resident had [redacted], was oriented to self with [redacted] and was an elopement risk. On [redacted] at 11:30 AM, the health and wellness coordinator confirmed the findings and said resident #2 was not identified as an elopement risk because he was not exit-seeking anymore. 2. On [redacted] at 10 AM, the Health and Wellness Coordinator identified resident #1 as being the only elopement risk in the building. During a tour of the facility on [redacted] at 10 AM, resident #1 was observed in her room. She did not have any identification on her person. The health and wellness coordinator searched for her identification but could not locate it. Resident #1's record revealed a resident health assessment form 1823, dated [redacted], that noted she had a diagnosis of [redacted], and was oriented to self with mild [redacted]. The health care provider noted she was an elopement risk. Further record review revealed the following incidents where she was exit-seeking: [redacted] B hallway - staff heard the alarm and redirected the resident [redacted] B hallway - the resident made it to the second door, staff heard the alarm and redirected the resident. - "Resident continues exit-seeking	A 032		

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A 032	Continued From page 9	A 032		

behaviors, resident was also aggressive and combative towards staff when redirected."
[redacted] - "Resident attempted to exit building through hall B She opened the outside door and took a step out....Caregivers caught the resident before she exited building. The caregivers attempted to redirect the resident, but resident was pushing toward the door. One of the caregivers hugged the resident from behind and pulled her inside. The resident bit her ."
[redacted] - "Resident exit seeking all day, but easily directed."
[redacted] - "Resident attempted to exit building on hall B. The caregiver apprehended resident and redirected her to play a game with the activities."
[redacted] - "Resident exit seeking all day. Easily redirected."
[redacted] - "Exit seeking this morning. Attempted to go to the front door of memory care and to the D hallway exit door. Resident was redirected without difficulty...staff took her on a walk."
[redacted] - "Resident attempted to exit through the C hallway exit door. Activity coordinator was behind the exit door on the phone and was able to get to the resident."

On , the resident attempted to open the door several times on her hallway and the staff were able to redirect her.

Review of the facility's elopement policy noted that residents living in a designated [redacted] 's and care community or unit shall be considered at risk for elopement. Residents identified as at risk for elopement should wear arm [redacted] identification containing the resident's name, community name and address and telephone number. Should be checked daily to determine the presence of their arm

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A 032	Continued From page 10 identification. If during the daily check, the resident is not wearing his or her identification, it should be noted in the resident's record. There was no evidence for resident #1 or resident #2 that noted they were checked daily for the presence of their arm . On at 12:15 PM, the administrator confirmed the elopement policy noted that all residents in the memory care unit were considered to be elopement risk per the company's policy. She said all residents in the memory care unit were not elopement risk. Class III	A 032		