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
	AL11953321	A. BUILDING: _____ B. WING _____	02/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRINGTON TERRACE AT BOYNTON BEACH	1425 S. CONGRESS BOYNTON BEACH, FL 33426

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A 000	Initial Comments AMENDED REPORT An unannounced Licensure Complaint (2020000867 & 2020012726), Focused . . . Control and Generator Monitoring survey was conducted on . . . . . to . . . . . at Barrington Terrace at Boynton Beach. The facility had deficiencies identified at the time of the survey.	A 000		
A 032	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of	A 032		

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A 032	Continued From page 1 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 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 reassess and provide appropriate supervision after a resident displayed	A 032		

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A 032	Continued From page 2 signs of unsafe . . . ˬ with a risk for elopement for 1 of 17 sampled residents (Resident #1). The facility failed to ensure residents identified as a risk for elopement had identification on their persons that included their name, and the facility name, address and telephone number for 9 of 17 at risk for elopement residents reviewed. The facility also failed to follow their own Elopement Policy and Procedure to prevent Resident #1 from eloping from the facility. The findings included: Review of the facility Elopement Policy and Procedure dated states in part: The purpose of this policy is to provide a system for identification of residents at risk for unsafe . . . ˬ or elopement, provide a program of supervision and intervention to minimize risk of the resident elopements, improve resident safety through timely investigation of elopements and elopement attempts, and provide staff education in effective ˬ/elopement management through in-service and elopement drills. Section "C" of the Policy Guidelines states - if a resident is determined to be at risk for . . . ˬ and Elopement, educational material will be available concerning the risk for Elopements. Specific intervention(s) will be provided to the resident and the family and will be documented in the resident's record. Further review of the policy labeled Elopement Risk Evaluation, indicates A ˬ/Elopement Tool is completed by a licensed member of the clinical staff for each resident to identify the level of risk which may lead to Elopement. Section "C" documents a ˬ/Elopement Risk Evaluation Tool item "C", will be completed, upon a change in status/condition as it relates to Unsafe	A 032		

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A 032	Continued From page 3 Resident #1 was admitted to the facility on . A review of Resident #1's admission Agency for Healthcare Administration Health Assessment (AHCA Form 1823) dated , revealed a medical history of Accident with left sided , generalized , difficulty in walking, with minor memory loss. Under Elopement Risk, Resident #1 was marked as "No". Further review of the form noted Resident #1 was independent with all activities of daily living (ADL's). On at approximately 12:30 PM, an interview was attempted with Resident #1 in the Memory Care Unit. Resident #1 was able to state her name, but question answers were not consistent with the questions asked. Resident #1 was observed to the unit and was to time and place. Review of Resident #1's electronic Observation Notes revealed the resident was having increased episodes of at risk , prior to being moved to the Memory Care Unit. On Resident #1 had an unwitnessed and was found lying on her floor by her door. Resident was unable to say how she got there. On Resident #1 was found on her bathroom floor, unable to explain how she got there. On Resident #1 is ambulatory but is and continued to walk in the hallway and has to be redirected several times. On a notation documents, spoke with son, regarding Resident #1's change in behavior and about her increased . Resident around in other resident rooms and attempts to remove items from the rooms or move her personal belongings to other rooms.	A 032		

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A 032	Continued From page 4 Spoke to the resident's physician and son was notified of the residents' behaviors. Also, spoke to the son about looking into the possibly of moving resident to the Memory Care Unit if this behavior becomes more permanent. On , Resident noted sitting on the floor on her living room carpet, denied falling stated she is fine. Resident stated she did not . On Resident was found sitting on the bathroom tub inside her room. Resident unable to move her left arm, sustained to the top of her , and resident had a to the left side of her . Resident was transported to hospital for evaluation. A review of a Physician Note dated , documented Resident #1 is noted with worsening and is requiring extensive redirection. The patient tries to and enters other patient rooms. She is difficult to redirect at times. On , Resident#1 was admitted to the Memory Care Unit. After the resident's increased episodes, the facility failed to complete a thorough risk evaluation to identify the level of risk and determine the need for increased supervision. Review of the AHCA Form 1823 dated , post admission to the Memory Care Unit, documents Resident #1 requires one person assistance with all ADLs except eating; observe well-being for readjustment to environment. Under Elopement Risk, Resident #1 was marked as "No". On at 10:20 AM, an interview was conducted with the Assisted Living Director of Nursing (DON) who stated on the date of the incident she was on duty. She stated on	A 032		

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A 032	Continued From page 5 . . . . . she received a call from the front desk at approximately 2:30 PM notifying her they found a missing resident in a nearby community. She stated she spoke to the local police department and they described Resident #1 and stated the resident told them her name. The DON stated she immediately went to the Memory Care Unit and conducted a count and verified Resident #1 was not there. She stated she was told Resident #1 was last seen at approximately 1:15-1:30 PM by staff after lunch. She stated the Administrator and herself went and picked up Resident #1 who was in one of the community members yard. Resident #1 was assessed, and she had no visible injuries. They returned to the facility and Resident #1's Physician and family were notified. The DON was asked how law enforcement knew the resident was from this facility, to which she stated they are the closet ALF to the community, so they called us first. The DON stated she called Staff B as a part of the investigation and the interview revealed Staff B stated the Fire Door alarm went off, she looked outside but did not see anyone. She stated Staff B stated she reported it to Staff F. The DON stated Staff B failed to do a count which resulted in Resident #1 being able to elope from the facility and had a count been conducted the resident would not have been able to travel as far as she did. On at 12:15 PM during an interview with the Memory Care Director, a request was made for a list of residents who were determined to be an elopement risk. A list was provided that documented the following 4 residents as elopement risk: Resident #1, Resident #4, Resident #5, and Resident #6. A review of AHCA Forms 1823 for Resident #11, Resident #12, Resident #13, Resident #14, and Resident #15	A 032		

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A 032	Continued From page 6 revealed these 5 additional residents were assessed by the Physician as being an elopement risk however were not included in the facility list of residents who were determined to be an elopement risk. 9 of 17 residents residing on the Memory Care Unit were identified as being high risk for elopement. On . . . . . at approximately 11:00 AM, the facility Elopement photo identification book which contained a photo and . . . sheet for elopement risk residents was reviewed and included Resident # 1, Resident #2, Resident #3, and Resident #4. Further review revealed Resident #11, Resident #12, Resident #13, Resident #14, and Resident #15 were not included in the Elopement photo identification book despite being assessed as elopement risks. On at approximately 12:00 PM, 17 of 17 residents observed in the Memory Care Unit did not have identification on their person with the facilities name address and telephone number. On . . . . . at 11:37 AM, an interview was conducted with Staff F who stated she was the Licensed Practical Nurse on duty the day Resident #1 eloped. She stated the day of the incident she saw Resident #1 sitting in the dining room at 1:25 PM. She stated she was in the office, but housekeeping was cleaning, and the TV was on and she did not hear the alarm and Staff B did not report the alarm going off to her. She said when Resident #1 was returned to the facility around 2 PM, that is when Staff B told her the alarm went off. It was determined the delay in Staff B responding to the door alarm made it possible for Resident #1 to elope from the Memory Care Unit and immediate facility grounds.	A 032		

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A 032	Continued From page 7 During an interview on at 12:30 PM with the Interim Administrator, Current Administrator, and DON, they acknowledged the findings. Class III	A 032		
A 086	59A-36.011(10) FAC Training - ADRD (10) AND RELATED ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between , and , shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled " and Related Level I Training," must address the following subject areas: 1. Understanding 's and related ; 2. Characteristics of ; 3. Communicating with residents with 's ; 4. Family issues;	A 086		

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A 086	Continued From page 8 5. Resident environment; and, 6. Ethical issues. (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility and Related . . . . . Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related . . . . . Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. and Related Level II Training must address the following subject areas as they apply to these : 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with 's . . . . . and Related ," dated , incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to	A 086		

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A 086	Continued From page 9 meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with or related , or 2. Three years of practical experience in a program providing care to persons with or related , or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with or related . (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g).	A 086		

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A 086	Continued From page 10 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all staff received training for and Related (ADRD) Level II within 9 months of hire for 3 of 4 sampled staff (Staff A, Staff B, and Staff C). The findings included: An employee personnel record review was conducted for Staff A whose hire date was , Staff B whose hire date was , and Staff C whose hire date was . Further review of the personnel records revealed no certificate of completion for 4 hours of ADRD training. At this time the business office manager was provided an opportunity to locate the documentation. During an interview with the Interim Administrator and the current Administrator on at approximately 12:20 PM, they acknowledged the findings and provided no additional documentation for review. Class	A 086		