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
	AL11911654	A. BUILDING: _____ B. WING _____	R 12/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OPAL AT CAPE CORAL	4920 VICEROY COURT CAPE CORAL, FL 33904

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{A 000}	Initial Comments An unannounced revisit survey was conducted on [redacted] through [redacted] at The Opal at Cape Coral, an assisted living facility located in Cape Coral, Florida. This was a follow-up to the complaint survey #2020014851 completed on [redacted]. The previous deficiency was found uncorrected.	{A 000}		
{A 025} SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises,	{A 025}		

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{A 025}	Continued From page 1	{A 025}		

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 and staff interview, the facility failed to properly supervise 1 (Resident #1) out of 3 resident records reviewed. Failure to provide adequate supervision and a secure environment for Resident #1 led to the resident's elopement on . While Resident #1 was unsupervised out of the facility, there was a high likelihood of serious injury, harm or . The facility failed to prevent/assess re-assess and provide interventions for residents with frequent for 2 (Resident #1, and #9) of 3 residents reviewed for .

The findings included:

1. Incident record review for Resident #1 found that on Staff D assisted the resident to bed. At midnight Staff A noted the resident was

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{A 025}	Continued From page 2	{A 025}		

missing. Staff A notified Staff B. Staff A, B, and D started searching the facility. At 12:15 a.m. they called Staff C. Staff C notified the police. Resident #1 was found by the local police at 1:35 a.m. and returned to the facility.

During an interview on at 2:30 p.m., Caregiver Staff A stated, "I think that night or the night before her daughter came to visit. You know when that happens it effects her . So that night out of the blue she came and found me with some CD's she told me [here take them]. I realized that was very out of character for her so I told Staff B, the overnight supervisor. She said put resident on 30 minutes monitor. So I took her to her room. I helped her change and she went to bed. It was 11:40 p.m. On my way there at 12:00 a.m., I saw her personal staff outside #. So, I immediately knew something was wrong and ran to her room. She was not there. I told staff B and D. We immediately started running around looking for her. Resident #1 knew the exit door was taking you down stairs. I went down the exit door. We knew she was gone after we searched the whole facility. We called Staff C. Staff C called 911 and came in. The police found her right behind the building at Victory street. She was there with her purse. Thank God she was fine. We brought her in. I stayed with her the whole night. I did not leave her for a minute. I was crying the whole night. After the whole incident with Resident #1 we did not have any other elopement. Just Resident #1 again, she tried again to escape and she and her . I was not here for that one. They told me they found her in an empty room. I know something was up with her. I think she had a or something."

In an interview on at 3:40 p.m. with the

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corporate executive director present, the Administrator in Training, Staff C, said on the night Staff A, B, and D called her to let her know Resident #1 was missing she came to the facility immediately. Two staff stayed on premises and one was driving around looking for the resident. She called 911 the fire department and police came. The police started looking on and the fire department around the building.
Staff C stated, "Resident #1 was found in the street at exactly the same address, but one street down. The house was not occupied. She helped herself into the lanai and sat on the front porch. She said she was found by the emergency medical service ( ). I passed her. I am a nurse. We brought her to her room. She then was placed on 1 to 1 overnight and 15 minutes checks after. She then was placed on 15 minutes, 30 minutes checks etc. No, I don't remember for how long we continued to monitor. A few days after she tried to leave again and was found in an unoccupied room. She had a and her . She ended up in the hospital. She is not coming . No, I don't remember the exact day and the room number. I will look in to it and i will let you know tomorrow."

On at 10:00 a.m., the administrator in training retracted her previous statement and said she spoke to staff that worked on and they told her the resident in her own room. She proceed on providing an incident report dated indicating at 3:30 a.m., the resident was found on the floor in her room. The administrator in training said she misspoke the date before. Actually the resident was found on the floor in her room and when they asked her she said she was trying to put her shoes on and she . Resident #1 was complaining of in her . An was ordered. She could not

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{A 025}	Continued From page 4 provide specific information or what hospital the resident went to. Per hospital records, the resident was admitted to the hospital on at 12:20 p.m., after a in the facility. Per medical record the resident obtained a of the left , and had surgery. Resident #1 was discharged to a skilled nursing facility for rehabilitation. On (the day before resident's) the physician note on record indicated Resident #1 made another attempt to elope from the facility. When the administrator in training, corporate executive director, and administrator on at 3:00 p.m. were asked if Resident #1 had another exit seeking episode before she her , on , the administrator in training said she did not have the specifics and she would ask the resident's physician and provide information the next day. The surveyor asked again on at 8:15 a.m., regarding the timeline of the exit seeking event prior to resident's on . Asked again on at 11:00 a.m., 12:30 p.m. and 2:30 p.m. At 2:35 p.m., the administrator said they could not provide the time line of the exit seeking behavior event. He said they did not know what exactly happened, what staff were involved or the location of the event. A physician visit note on indicated the following: "Patient noted to have a last week while outside in the courtyard. The was witnessed by other residents stating the resident was attempting to sit down in a chair outside however she seemed to have missed the chair and slid and landed on her left side. At that time resident was complaining of right arm , and it	{A 025}		

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{A 025}	Continued From page 5 was not that she had . . . . . on her right upper arm. Patient denied of other injuries." During an interview on at 11:20 a.m., the administrator in training did not provide documentation related to Resident #1's or re-assessment, or new interventions after the . . She said they did not have any documentation. She also said they do not have a . assessment/re-assessment tool or policy and procedure. 2. During an interview with Resident #9 . . . . . at 2:00 p.m. he said, "It was few days ago. That medication they are giving me . . . , . makes me . I had a nasty . I could not get up. I kept pressing my pendant. It took 3 hours for them to come and get me off the floor. My daughter called 911. They took me to the hospital. I am fine. They brought me . yesterday or the day before, I think." The . assessment for Resident #9 dated indicated the resident did not have any . . in the last 3 months. Record review for Resident #9 found he had a . on . Per a note on record, Resident #9 was found on the floor next to the bed. Resident #9 said he was laying in bed, leaned over and out of the bed. Resident #9 was assessed. The family and physician were notified. The 72 hour post-. protocol was followed. On the resident was found on the floor and stated he was trying to get . . in bed and . Resident #9 was assessed and there were no negative outcomes. Post . protocol was followed. On a physician note on record indicated	{A 025}		

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{A 025}	Continued From page 6 the following: "Assisted living staff report last week which patient suffered a . Patient seen today and stated that he was laying in his bed and reached over to bedside table and slid out of the bed. He states that his hit his bedside table. He denied any difficulty ambulating after that. Patient said he had another in the bath room and when he was leaning to sit on the toilet felt weak and onto the toilet. There were not injuries at the time." No documentation found on record of Resident #9's recent . No incident report or post protocol on record. In an interview on at 3:40 p.m., the administrator in training confirmed Resident #9 had a and ended up in the hospital. She said she did not have the specifics since there was no incident report on record. She also confirmed no new interventions after the most recent . Hospital records for Resident #9 revealed the resident arrived at the hospital on at 4:17 a.m., after he had a and his family called 911. Resident #9 was assessed and returned to the facility the next day. In an interview with the maintenance director on at 12:38 p.m., he said he checked the resident's pendant after the he had last week on the 5th. He said there is a system in place to check and see how long it takes for staff to respond to a call light. He said all caregivers have a pager. When the pendant is pressed they will get a message on their pager. When they respond to the call light they will press the pendant to go off. He said he can monitor responses only for existing residents but he can	{A 025}		

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{A 025}	Continued From page 7 not go . . . and check for residents that are no longer in the facility because their room is occupied by another person and they monitor with room numbers. He proceed showing the pendant log response for Resident #9. Per the log on , Resident #9 pressed his pendant on 9:21 p.m. and staff responded to him 83 minutes and 57 seconds after. Previous pendant call on 8:52 a.m. and response was after 99 minutes and 59 seconds. On call on 12:05 p.m. and response was 57 minutes and 4 seconds after. There was no . . assessment policy and procedure. During an interview on at 10:00 a.m., the administrator in training said she spoke her self to Resident #9's physician yesterday specifically about Resident #9's . . . . , . . since the resident complained that medication made him , . She said Resident #9's physician told her he (Resident #9) needs to continue on that medication and he will be unstable if he is taken off , . No other medication review was made. Medication record review for Resident # 9 found he had a prescription for 100 milligrams (mg) from . . . . . (date of last . assessment) to . There was a dose decrease to 50 mg on . . . . . to present. There was no documented evidence the resident was seen by a psychiatrist to evaluate the use of this medication or what effect it may be having on the resident's . . . . . has side effects that include . . and drowsiness. Class II	{A 025}		

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