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
	AL11967991	A. BUILDING: _____ B. WING _____	03/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND OAKS	203 SE 2ND STREET OKEECHOBEE, FL 34974

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An Abbreviated Relicensure, Focused Control and Generator Assessment survey was conducted on at Grand Oaks. The facility had deficiencies at the time of the visit.	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 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.	A 032		

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A 032	Continued From page 1 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 interviews and record review, the facility failed to conduct required resident elopement drills for 2019 and 2020 and failed to ensure administrators and direct care staff participated in two resident elopement drills each year. This has the potential to affect any residents at risk for elopement.	A 032		

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A 032	Continued From page 2 The findings included: A review of the facility's resident elopement response Policies and Procedures, including training and elopement drills was conducted on . Review of a policy dated titled Elopement, revealed Item 7. "There shall be a minimum of 2 elopement drills conducted each year." Further review of documentation located in the written Policies and Procedures revealed the following: 1. A document dated titled "Staff Meeting" held signatures for 14 attendees. A two-page "All Staff Meeting" agenda included paragraphs of information related to multiple subjects, and included, "Fire & Elopement Drill/Education". An attached two-page written policy dated was titled, "Elopement Standards (Reference: Tag ST0032)". It included resident elopement policies and procedures but did not reference facility staff conducting actual resident elopement drills. Eight caregivers signed the attendance sheet, there was no documentation showing the Administrator participated. There was no documentation showing an actual elopement drill was conducted based on the facility's written resident elopement Policies and Procedures. 2. A document dated titled "Resident Council Meeting & Fire Drill Education" with "/Elopement Drill/Education 2nd floor" -written next to it, and 12 attendees. Of the 12 attendees, 9 were residents, 2 were direct care staff. There was no documentation showing the Administrator participated. There was no documentation showing an actual elopement drill	A 032		

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A 032	Continued From page 3 was conducted based on the facility's written resident elopement policies and procedures. 3. A document dated titled "Resident Council Meeting & Fire Drill Education" with "/Elopement Drill/Education 3rd floor" -written next to it, included 15 attendees. Of the 15 attendees, 9 were residents, two were direct care staff, and two staff names were illegible. There was no documentation showing the Administrator participated. There was no documentation showing an actual elopement drill was conducted based on the facility's written resident elopement policies and procedures. No documentation showing the required elopement drills were conducted during 2020. 4. An Elopement Drill form dated documented 3 staff members participated in the elopement drill. There was no documentation showing the Administrator or the other direct care staff participated in the elopement drill. 5. An Elopement Drill form dated documented 4 staff members and the Administrator participated in the elopement drill. There was no documentation showing all direct care staff participated in the elopement drill. In an interview conducted on at 1:47 PM with the Administrator present, the Nurse Manager stated they currently have 11 Caregiver staff members. At 2:14 PM, these concerns were further discussed with the Administrator. She stated she started with the facility in , and this was all the documentation she knew of. At 3:00 PM with the Administrator present, the Nurse Manager stated they conducted elopement education in thinking they were drills based on the facility's resident elopement	A 032		

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A 032	Continued From page 4 policies. They both acknowledged the staff meetings in were not elopement drills, and further acknowledged the elopement drills conducted during 2019 did not include the Administrator and all direct care staff. Class III	A 032		