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
	AL11964031	A. BUILDING: _____ B. WING _____	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE STUART	3401 SE ASTER LANE STUART, FL 34994

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A 000	Initial Comments An unannounced Complaint survey (#2021004387 & #2021004435) was conducted on through at Brookdale Stuart. The facility had deficiencies identified at the time of the visit.	A 000		
A 025	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		

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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 interview and record review, the facility failed to ensure residents were safe and supervised to prevent the elopement of 1 of 3 sampled residents, Resident #1. As evidenced by Resident #1 had the ability to exit the facility unnoticed, secure a vehicle with the keys in it and drive off the facility property, putting the resident, other drivers and pedestrians at risk of being injured. The findings included: Review of Resident #1's record revealed she was admitted to this secured facility on .	A 025		

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A 025	Continued From page 2 Review of the resident's Health Assessment 1823 dated , documented the resident's diagnoses to include 's with memory , . The resident was assessed as not an elopement risk at the time of admission. On at 5:00 PM, a telephone interview was conducted with a family representative of Resident #1 who stated Resident #1 was recently relocated from an Assisted Living Facility out of state. The family representative expressed she was moved into this secured facility to ensure the resident's safety during her transition to a new environment. Review of the Brookdale informational website for this facility advertises 'At Brookdale, assisted living also means having a healthy, secure environment to enjoy life in. You'll get that from our 24-hour security system, or the fact that we have an emergency response available 24/7. Review of the informational video clip on the Brookdale website states, 'Your family has peace of mind knowing our staff is on site 24 hours a day, 7 days a week.' Review of Resident #1's record revealed on , Resident #1 eloped from the facility. Further review revealed the resident walked out of this secured facility at approximately 3:10 PM unnoticed through an exit door whose alarm had been disengaged. In the facility parking lot, the resident got in a truck that had keys inside of it and drove off the facility property. The resident was apprehended by police on at approximately 3:40 PM by engaging a 'pit' maneuver (planned car crash) for being observed driving erratically down US Route 1, a busy main thoroughfare. During this time Maintenance Director (Staff A), the owner of the truck and an employee of the	A 025		

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A 025	Continued From page 3 facility, was with a police officer who arrived at the facility to take the report of his stolen truck. While the police officer was at the facility taking Staff A's stolen truck report, the officer reported the stolen truck over the police radio. Review of the Police Report dated at 3:30 PM, the police officer documented in part, 'While I was giving this info to dispatch, they stated that (name of County Police) was behind the vehicle and they were attempting to stop it. Dispatch advised that (name of County Police) then pursued the vehicle for approximately 20 minutes or so at variable speeds southbound on US 1. Dispatch stated that (name of county police) conducted a pit maneuver to get the vehicle stopped. I relayed this information to Staff A and told him they were able to stop the vehicle. County Supervisor then contacted me via phone and questioned me about the occupants of the vehicle stating it was a female ... . Staff A did not know anyone that could be in the vehicle and we determined that it could possibly be someone from the assisted living facility across the street. Initially it was advised to me that all persons from Brookdale were inside, due to it being a secured facility. I was then provided with a picture from the County Sheriff Office of the female, at which time I showed it to Staff A as well as the Executive Director who did advise it was one of their residents. County Sheriff Office advised that Fire Rescue was going to transport her to the ER (Emergency Room) at (name of hospital) to check on her due to her not knowing where she was or what was going on .....While on scene I observed (name of resident) arrive with family members who had just picked her up from (name of hospital). (Name of Resident) appeared to have no idea of what occurred and had no idea what had happened.'	A 025		

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A 025	Continued From page 4 Resident #1 who was recently relocated to this facility from another Assisted Living Facility in another state and who was not familiar with her location and surroundings, drove 17 miles away from the facility in a truck she had taken from the parking lot of the facility and which had to be forcefully stopped by police as she was not complying with police to pull the vehicle over. It was reported in the local newspaper there were no personal injuries to other motorists or pedestrians as a result of the police chase. Staff at the facility were not aware the resident had eloped from the facility until her picture was shown to them by the police officer on scene at the facility. At this time, the facility conducted a count to confirm Resident #1 was missing. Resident #1 was returned to the facility at approximately 6:10 PM, 3 hours after she exited the building unnoticed. On at approximately 12:00 PM an interview was conducted with the Executive Director who stated they conducted an investigation immediately following the incident. She stated she identified the exit door the resident used to elope had a green light visible, indicating the door alarm and automatic lock was disengaged. She determined the door " " security code (different from the regular code) had been entered to allow unlimited entry or exit time with no alarm or lock engaged, until the " " code is reentered. She further stated only herself, the Business Office Manager Staff C and Maintenance Director Staff A had access to this code. She stated it was still unknown who entered this code to turn the alarm and automatic lock off on . Review of the facility's Elopement Risk Policy	A 025		

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A 025	Continued From page 5 documents the facility requires a resident identified at risk for elopement to wear an arm identification with the resident's name, community name and address, and telephone number. The policy also states this identification will be checked daily, and a note will be recorded in the resident's record if the resident is found not wearing the identification arm . Review of facility records revealed Resident #1 was not provided with an identification arm upon her return to the facility after the elopement. On at approximately 11:00 AM, an interview was conducted with Licensed Practical Nurse (LPN) Staff B, who stated Resident #1 was not provided with an identification arm after her elopement. The reason for not ensuring the resident had identification on her person after the elopement was undetermined. Review of the facility's Missing Resident Drill Policy states the facility is required to conduct elopement drills quarterly for all shifts or per state regulation, minimum of twice per year. Review of the personnel record for LPN Staff B revealed she had not participated in any elopement drills within the previous year prior to Resident #1's elopement on . Further, during the interview conducted with the Executive Director on at approximately 12:00 PM, she stated Resident #1 was considered an elopement risk after her elopement from the facility on . The Executive Director further confirmed Resident #1 was not provided with an identification arm upon her return to the facility. The reason for not ensuring the resident had identification on her person after the elopement was undetermined.	A 025		

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A 025	Continued From page 6 In the telephone interview conducted with Resident #1's family representative on at 5:00 PM, the family representative stated on they relocated Resident #1 to another Assisted Living Facility that had a locked secured Memory Care Unit for her safety. Class III	A 025		
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	A 032		

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A 032	Continued From page 7 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 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)(i), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the	A 032		

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A 032	Continued From page 8 facility failed to identify 1 out of 3 sampled residents (Resident #1) who was at risk for elopement by maintaining identification on the resident, and by making a daily effort to ensure the resident is wearing the identification; and, failed to include 1 out of 5 sampled staff (Staff B) in a minimum of two (2) elopement drills annually. The findings included: 1. On [redacted] at 12:00 PM, the Administrator agreed during interview that Resident #1 was at risk for elopement as of [redacted], after eloping front the facility. She stated that the resident did not have identification on her that was checked daily while at the facility. During interview with Staff B on [redacted] at 11:00 AM, she also acknowledged the elopement on [redacted], and stated that the resident did not have any identification on her while a resident at the facility. Review of the facility's Elopement Risk Policy revealed that the facility requires a resident identified at risk for elopement to wear arm identification containing the resident's name, community name and address, and telephone number. The policy also notes that this identification will be checked daily, and a note will be recorded in the resident's record if the resident is found not wearing the identification arm . Resident #1 was not provided an arm that was checked daily for application after eloping and returning to the facility on . The resident was discharged on . 2. The facility's Missing Resident Drills Policy notes that the facility is required to conduct elopement drills quarterly for all shifts or per state regulation, minimum of twice per year. On	A 032		

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A 032	Continued From page 9 . . . . . , the personnel file for Staff B was reviewed for participation in elopement drills. Staff B had not participated in any elopement drills documented within the previous year, prior to Resident #1's elopement on . . . . . . These findings were acknowledged by the Administrator on at 1:00 PM. The facility provided no additional information for review at this time. Class III	A 032		