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
	AL11965625	A. BUILDING: _____ B. WING _____	05/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(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 unannounced licensure complaint survey, #2021007161, was conducted on . . . . . and at Active Senior Living Residence. The facility had a deficiency identified at the time of the survey.	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 observation, interview and record review the facility failed to provide adequate supervision and implement measures to ensure the safety of residents for 1 of 4 residents reviewed for supervision, Resident #1. As evidenced by the facility failing to supervise and monitor the whereabouts of residents resulting in Resident #1 eloping from the facility's secure Memory Care Unit unnoticed. Further, the facility failed to notify the responsible representative of a change in condition for Resident #1 when it was discovered she had , with subsequent treatment of the . . , and no investigation into the source of the identified on	A 025		

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A 025	Continued From page 2 Resident #1. The findings included: 1) A review of the facility's informational website was conducted on which advertises under Living Options, the facility has a Memory Care Unit. The description of the Memory Care Unit states, 'Memory Care-Specially designed environments and associates trained to care for seniors living with challenges, including and . Our communities provide a safe, secure environment with personalized care to each of our residents. We feature great amenities and secure outdoor spaces.' Review of the clinical record for Resident #1 revealed she was admitted to the facility's Memory Care Unit on with diagnoses to include and . Review of the Resident Health Assessment completed by the Advanced Registered Nurse Practitioner (ARNP) dated documents the resident has an unsteady gait, requires assistance with ambulation, is prescribed and medications, is not an Elopement Risk, and the resident's needs can be met in the assisted living facility. On at 3:43 PM, a telephone interview was conducted with 2 family members of Resident #1 who stated Resident #1 lived with them and it was getting impossible, she would not stay in the house, stating you would go to the bathroom and by the time you got out she was gone. One minute she was there, the next gone, like Houdini. She liked to leave the house and hide behind bushes. They further stated they had	A 025		

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A 025	Continued From page 3 to admit her to a secure unit because they were constantly outside looking for her, it was dangerous, she could get hurt. The family member stated the resident is very at the facility, she wants to leave all the time, and it seems to be getting worse. The family members confirmed Resident #1's behavior of and exit seeking was relayed to the facility on her admission. Review of the Resident Observation Log for Resident #1 revealed the first entry since the resident's admission on is dated by the Licensed Practical Nurse (LPN) Charge Nurse, 5 days after admission, documenting 'Was reported that resident was admitted on Thursday evening.... Resident has been attempting to run out the gates of facility per staff, , alert and .... Placed in Memory Care Unit... Staff alerted and elopement precautions.' Review of the Job Description for the Facility Nurse/Licensed Practical Nurse states in part, 'A Facility Nurse: Checks on each new resident for 5 consecutive days and documents on their status including attitudes towards adjustment to facility.' Resident #1's first assessment was done 5 days after her admission. Review of a Resident Status Evaluation dated completed by the LPN Charge Nurse documents in part, Resident #1 is , , ambulates independently and under elopement precautions. Review of a Clinical Note completed by the ARNP dated documents in part, ' is on the decline and needs help with all ADLS (Activities of Daily Living); Unsteady on .'	A 025		

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A 025	Continued From page 4 Review of a Resident Health Assessment completed by the ARNP dated documents the resident has an unsteady gait, requires assistance with ambulation, is prescribed , and , , medications, is not an Elopement Risk, and the resident's needs can be met in the assisted living facility. This Resident Health Assessment was signed and acknowledged by the LPN Charge Nurse as the facility Designee on . On , Resident #1 eloped unnoticed from the facility's secure Memory Care Unit. She was located by local police 2.3 miles away from the facility. On at 9:40 AM, a telephone interview was conducted with a representative of the County Police Records Department, who was able to retrieve the Missing Person Report dated for Resident #1. The representative stated the Police (Department A) received a call from the facility on at 7:51 PM and Officer (Last Name) responded to the call. She stated a BOLO was put out to the surrounding cities as the missing person was considered a high risk due to her age and mental status residing in a Memory Care facility. The representative stated someone at (name of restaurant) in the neighboring city called Police (Department B) at 8:35 PM as there was a woman who came in who looked . The representative stated Police (Department B) were not aware the woman was Resident #1 until 8:53 PM and Resident #1 was reunited with Police (Department A) and returned to the facility by Police (Department A) thereafter, the exact time of return was not available.	A 025		

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A 025	Continued From page 5 Review of the Florida Healthfinder.gov website was reviewed under this facility name and the Facility Locator Directions site was accessed to determine the distance between the facility and the restaurant where Resident #1 was found. According to the directions, the restaurant is 2.3 miles away from the facility. It cannot be determined what route Resident #1 walked to reach the restaurant. However, the following is an example and would have been the most direct route. The distance from the front door of the facility to Pine Island Rd. is 0.2 miles. Pine Island Rd. is a busy thoroughfare with 3 lanes going south and 3 lanes going north. From the intersection of the facilities street and Pine Island Rd., is Commercial Blvd. about 20 car lengths distance south from this intersection. Commercial Blvd. has 3 lanes going east and 3 lanes going west with left turning lanes in addition to the 3 north and south bound lanes also with left turning lanes at the intersection of Pine Island Rd. and Commercial Blvd. To get to the other side, the resident would have crossed over 7 traffic lanes to include a turning lane to get to the south side of Commercial Blvd. Continuing south on Pine Island Rd. the resident would have reached Oakland Park Blvd. which is the same busy street scenario as Commercial Blvd. and Pine Island. To get to the other side, the resident would have crossed Oakland Park Blvd. over 7 traffic lanes at the intersection of Oakland Park Blvd. and Pine Island Rd. and reached her destination, the restaurant, which was located on the right, or west side of Pine Island Rd. This route was 2.1 miles with the total route being 2.3 miles from door to door. Review of the report submitted by the facility Administrator to the State agency dated documents the timeline as follows:	A 025		

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A 025	Continued From page 6 At 6:00 PM, the door exit alarm is set off. At 6:03 PM, staff check the alarm and discovered a resident could have left the building. Staff go outside to investigate the immediate area and had no sign of resident. At 6:05 PM, staff started to conduct a search to see if they can identify the missing resident. At 6:10 PM, identified it was Resident #1 on our memory care unit. There was a small gate that separated the courtyard from memory care from the assisted living part of the community. Resident #1 climbed over the gate and went out the west fire door. At 6:15 PM, the Administrator was notified. At 6:30 PM, the Administrator arrived and conducted his own search. At 6:45 PM, POA (Power of Attorney) was notified. Asked if they might know of any areas they could check outside of the facility that she might be. At 7:45 PM called Police (Department A), arrived within 5 minutes. They conducted their own search and put out an alert for the surrounding cities and law enforcement. A report was made by a local restaurant that they have a woman who looks _____ so Police (Department B) responded and confirmed it was Resident #1 and brought her ___ around 10 PM by Police (Department A). Upon return to the facility the physician was called and advised to send the resident to the hospital for evaluation because it was unknown of her exact whereabouts before she was found. The resident returned (no time documented) with no found injuries or ___. Review of the clinical record for Resident #1 revealed no documentation regarding what time and with whom Resident #1 was sent to the	A 025		

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A 025	Continued From page 7 hospital on . . . . . and no documentation of the time the resident returned from the hospital post evaluation after the elopement. Further review of the clinical record for Resident #1 revealed a hospital Discharge Instruction pamphlet titled 'Patient with . . . . ' dated at 11:12 PM, with instructions that stated in part, 'Be sure someone is with the . . . . . person at all times. He or she should not be left alone or unsupervised.' Review of the facility's Policy and Procedure Manual binder on at approximately 1:00 PM, revealed the facility, which has a Memory Care Unit, did not have a policy that addresses Resident Supervision. Review of the facility undated Policy and Procedure for Elopement states in part, 'The priority of the facility is to foster an environment of safety and good quality of life for all residents as much as possible....The preliminary search efforts should last no longer than an hour from the time the resident was reported missing....If the missing resident is still not discovered during the preliminary search, the Administrator must be notified. The Administrator then assumes onsite responsibility for continuing the search, including notification of outside agencies such as the local police department.' Review of a website address called timeanddate.com, it documents sunset occurred at 7:39 PM on , ... Traversing these busy multilane roads and intersections during daylight and during night time hours, placed Resident #1 at high risk for getting hit by a car and sustaining serious injury or	A 025		

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A 025	Continued From page 8 Review of Resident #1's clinical record revealed a Resident Observation Log entry by the LPN Charge Nurse dated , no time documented, stating, 'Resident appears . Attempting to get through memory care fence.' Review of Resident #1's clinical record revealed a Resident Observation Log entry by the LPN Charge Nurse dated , no time documented, stating, 'Resident continues to attempt to get past gates.' Review of Resident #1's clinical record revealed a Resident Observation Log entry by the LPN Charge Nurse dated , no time documented, stating, 'Resident , pacing, pushing staff and attempting to get through gates of memory care.' On at 10:35 AM, a tour of the Memory Care Unit was conducted with the LPN Charge Nurse and facility Owner. The LPN Charge Nurse gained entry into the unit via a numbered touch , code to the left of the doorway. The resident rooms are located to the right down a concrete walkway, all doorways out to the exterior courtyard. The current census was 10. To the left of the entry door is an outdoor dining area for the memory care residents with 4 tables and 8 chairs. One male resident and one female resident were observed seated at one table, one female at another table. Resident #1 was observed seated next to Resident #2 against the wall to the right. Resident #1 who is an elopement risk was not wearing any identification bracelet. Resident #1 got up, sat down, got up and walked down the walkway then , then walked up to the fence then to sit down next to Resident #2. An observation was made of a white picket fence approximately 4 high in an L shape extending	A 025		

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A 025	Continued From page 9	A 025		

from the outdoor dining room area and down the walkway where the resident rooms are located. At the dining room area 2 panels of lattice were attached to the fence almost to the ceiling with a lock observed on the exit gate. Black mesh netting was attached to the fence in front of the dining area and the rest of the picket fence was observed to be open at the top. Near the end of the walkway across from the resident's rooms was a gate which led to the residents who reside on the Assisted Living (AL) side of the facility. These resident rooms also [illegible] out to the exterior courtyard. Lattice panels almost to the ceiling were observed attached to the top of the locked gate which leads to the walkway of AL residents. The amount of area of picket fence with no lattice is about half the length of the fence line. Hedges were planted on the other side about 3 quarters of the [illegible] of the picket fence and set [illegible] from the fence on the other side. An inquiry was made to the Owner about this area still open where residents could still climb over the fence to which he stated no resident has attempted to do so. The scenario was reviewed how Resident #1 was able to elope. According to the Owner, Resident #1 pulled a chair over to the gated fence, climbed over the picket fence, walked down the walkway past the AL dining room, went through the activity room door which was unlocked, out the other door on the other side, turned right down the hallway of the AL past [illegible] and exited out the west door which is alarmed. During this discussion Resident #1 was observed pacing up and down the walkway in front of resident rooms. Observed at the end of the walkway, one room away from Resident #1's is a locked iron gate leading to the [illegible] of the building with a concrete landing and stairs leading down to a grassy area and a chain link fence surrounding a lake which belongs to

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A 025	Continued From page 10 the apartment . . , . . behind the facility. Access through this iron gate is obtained by lifting a plastic cover over a green button located in the upper right corner and pushing the green button which unlocks the door. Observed posted on the iron gate was a red sign with the directions - 'To Open Door - Push button at upper right side.' On . . . . . at 10:44 AM, an interview was conducted with Resident Assistant Staff A, who stated she works the Memory Care and the AL sides. She stated on the evening of the elopement she was working on the AL side but she watches both sides. She stated another aide was working in Memory Care that night and she just went to the laundry. Staff A stated Resident #1 is always walking, further stating we all know to keep a close , on her. She stated the west door alarm went off and another aide working in the front went to see why the door was beeping around 7:30 PM. She stated the aide looked out but did not see anyone. She stated then we decided to check all the rooms room by room, checked bathrooms and closets and she told another aide on the AL side I think we lose Resident #1. She stated she went to the front of the building nursing station where the Medication Technician was stationed and asked if she saw anything and she said she did not. Staff A stated we could not find Resident #1 so she stopped everything got in her car and started driving around but did not see anyone. Staff A stated Resident Assistant Staff C who was working the Memory Care that evening last saw Resident #1 about 7:15 PM. She was busy in another room with another resident and did not see Resident #1 leave. An inquiry was made to Staff A regarding how many staff work on the Memory Care Unit to which she confirmed there is one staff for the Memory Care on all shifts and the aides from the	A 025		

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A 025	Continued From page 11 AL side help out and check on residents when they can. An inquiry was made to Staff A if the census is currently 10 residents how does one person supervise all ten residents to ensure the residents are not trying to climb over the fence; to which she stated it is not easy because if you are with another resident in a room with the door closed you don't know what is going on out here. A request was made to Staff A to identify which residents residing on the Memory Care Unit were independently ambulatory. Staff A identified 4 residents to include Resident #1, in addition to Resident #2, Resident #3 and Resident #4. On . . . . . during the interview being conducted with Staff A at 10:44 AM, music was playing overhead and Resident #4 was observed to be dancing while hanging onto the picket fence. Resident #4 was not interviewable. Further observations were conducted of Resident #4 at 12:30 PM and 3:00 PM as she was pacing . . . and forth then sitting in the chair in the outside dining area then . . . up again. Resident #2 was observed at these times ˳ around the outside dining area then sitting in a chair by the wall to right of the door then up again. Resident #3 was also observed walking and pacing and forth at 10:45 AM and 3:00 PM. Resident #1 was observed to be the most active, pacing continuously during observations conducted at 10:50 AM and 12:30 PM on . Resident #1, who is a high risk for elopement was observed to not be wearing any identification bracelet. Resident #2, Resident #3 and Resident #4, identified as ambulating independently in the Memory Care Unit, were not wearing an identification bracelet or any other form of identification. On at 10:53 AM, the Memory Care unit	A 025		

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A 025	Continued From page 12 was exited with the LPN Charge Nurse and facility Owner. The LPN Charge Nurse entered a code into the number touch , to the right of the exit door. At this time, the surveyor observed posted just under the number , is the code to exit the unit - (X X X X *). Two of the 5 exits from the Memory Care unit have directions posted on how to get out through those doors and the portion of the L shaped picket fence that does not have the lattice panels is not a deterrent to keep residents from climbing over, as is evidenced by Resident #1 making at least 4 attempts to crawl over the fence and leave as is documented in her Resident Observation Logs from through . On at 10:54 AM, observation was made with the LPN Charge Nurse and facility Owner of the west exit door down the AL hallway where Resident #1 eloped. The facility Owner opened the door which made a loud piercing alarm. Outside the door is a raised sidewalk to the left and directly in front is a ramp with a , parking area. There is a grassy area to the right of this. Walking left down the raised sidewalk leads to the front parking lot and front of the building. Walking through the parking lot past the front door leads to the facility driveway leading to a 2 lane road with a grassy boulevard in between the lanes. Pine Island Rd is easily visible from the end of the driveway. To the left of the facility is a large commercial building with a large parking lot. To the right of the facility is what looks like a end with a 6 chain link fence surrounding a construction site. Directly across from the facility is a construction site with a 6 chain link fence. Mounds of dirt were observed beyond the fence with some construction equipment. Going east (left) from the facility, on the right side is a pharmacy and fast food restaurants. There	A 025		

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are trees and bushes surrounding these establishments. Looking down the street the facility is located on, there is a clear view with no obstructions of viewing the road or sidewalk. An inquiry was made to the facility Owner and LPN Charge Nurse, if staff responded to the door alarm immediately how did nobody see the resident walking down the sidewalk or the road. They both replied they were not here and maybe the resident is a fast walker.

On at 11:30 AM, a telephone interview was conducted with the Administrator and an inquiry made about the timeline of the elopement where staff are saying one time and he has documented an earlier time on the State report. The Administrator stated he received a call from the evening Supervisor around 6:15-6:30 PM, that Resident #1 walked out about 6:00 PM. He stated an aide was working with a resident in on the AL hallway and when the alarm went off she checked out in the hall and outside, it was just a few minutes after the alarm sounded. He stated she let the evening Supervisor know saying she thinks someone is out of the building. They then initiated the elopement procedure and found that Resident #1 was not in her room. A further inquiry was made about the timeline the aides saying it was around 7:30 PM and he documented on his report it was 6:00 PM, to which he stated he did the report correctly. An inquiry was made if he got the 6:00 PM timeline from watching their camera surveillance video footage to which he stated the cameras were on but not recording, he would have seen it in real time on his phone but he was not watching his phone, he was in his car driving. He stated when he got the call he turned around and came to the building and the Owner came to the building also. Another inquiry about the time line discrepancies was made to which he

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A 025	Continued From page 14 stated his main concern was the safety of the resident and he did not pay much attention to the time. An inquiry was made if he checked his cell phone to see what time he received the call from the facility Supervisor, to which he had no comment. He stated he called the police about 7:30 PM when they could not find the resident after their search and the Police (Department A) showed up and they put out a BOLO (Broadcast issued from law enforcement agency to other law enforcement agencies) and had helicopters in the air looking for her. He stated they called the resident's family to find out if the resident had a favorite spot to go to and he said they told him they were not familiar with the area and Resident #1 was not familiar with the area either. He stated Police (Department B) found the resident in a restaurant and she was brought by Police (Department A). When she got he stated the Owner wanted her to go the hospital to get checked out as she was gone a while and they did not know where she was or who she was with so they wanted her evaluated to make sure she was ok. An inquiry was made what they have implemented since the elopement to which he stated they put up the lattice on the fence, it is temporary until they get a nicer looking fence and maintenance put a stopper on the resident's window so she can open it but cannot crawl through it. Additionally he stated they put a plastic cover over the green push button to get out the iron gate. The Administrator stated once in a while she will try to hop the gate, she is still very with it. An inquiry was made about the evening staffing which he explained there were 3 aides plus a Medication Technician on evenings for the AL side and one aide for the Memory Care unit. On the night shift there is one aide for the AL side and one aide for the Memory Care unit and no Medication Technician as there are no	A 025		

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medications given on the night shift. An inquiry was made since Resident #1 eloped on have they increased their staffing levels on the Memory Care unit to ensure increased supervision to which the Administrator confirmed there is one aide scheduled and dedicated to work on the Memory Care unit per shift. He stated he would like to have 3 staff on the night shift but he cannot find anyone. He stated his phone is always on and staff cannot cover every shift, further stating 'We need time off too'.

On . . . . . at approximately 10:30 AM, the Administrator provided a letter documenting the measures that have been put in place or will be put in place since Resident #1's elopement on . The measures do not include increasing staffing in the Memory Care Unit from only one staff member on all shifts to increase the supervision of the residents in , those residents who have been identified as elopement risks and have a known history of eloping.

On at 12:20 PM, an interview was conducted with Resident Assistant Staff B working in the Memory Care Unit. She confirmed her assignment was the Memory Care Unit and she was in charge of 10 residents. An inquiry was made if she was familiar with Resident #1 and she stated you have to keep an , on her at all times because she walks all the time and will try to hop over the fence. The lunch meal was in progress with 8 residents seated at tables eating independently. One resident was observed seated in a wheelchair in the interior dining/activity room not eating and one resident was seated in a gerichair next to the other residents who were eating. This resident was not being fed or assisted while she sat there watching the other residents eat in front of her. An inquiry

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A 025	Continued From page 16 was made to Staff B why this resident was not being fed or assisted to which she stated the food is too hot. The resident's lunch meal was observed sitting on top of the food cart in Styrofoam containers covered with plastic wrap for the past 5 minutes. At 12:25 PM, Resident Assistant Staff A arrived and confirmed the staffing for the Memory Care Unit is one staff on all shifts. She stated the people who work on the AL side will come and help when they can. An inquiry was made how does one person assist residents with morning care and other activities of daily living for example . . . . . care to which she stated 6 of the 10 residents are . . . . . with assistance, you have to help them to the bathroom and there are 6 residents who are under hospice and hospice staff comes in 7 days a week and they do the morning care for those residents so it makes it easier to handle the other residents when they have this help. An inquiry was made if there is one staff person on per shift, and that staff person is in a room with a resident with the door closed, how are the other residents supervised to which she stated it is hard, we do what we can do. While interviewing Resident Assistant Staff A, Resident #1 came up to this surveyor and asked "Where is the exit to the street?" Resident #1 was observed to be pacing up and down the walkway, going into her room, coming out and walking . . . and forth again. Resident #1 was observed to be very active. On . . . . at 12:45 PM, a rough estimate of the time it would have taken Resident #1 to get from her room to the west exit door in the Assisted Living (AL) corridor of the facility was conducted. The test started on the opposite side on the AL walkway because the exact route she would have	A 025		

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taken is now locked and has the lattice fencing so one could not attempt to pull a chair up and hop over at that exact area. Walking at a normal pace down the same length of walkway the resident would have done, turned left through the courtyard access to the AL activity room, exiting right through the interior AL activity room door, down the AL hallway past to the west exit alarmed door took 1 minute and 27 seconds. This time did not account for the resident retrieving a chair, pulling it up to the fence, hopping over the fence to the other side and carrying on her way. It also did not account for her possibly stopping at the activity doorway to determine if she was going to go left or right and if she possibly stood at the exit door for a couple of seconds before actually exiting the building. The 1 minute and 27 second test run was the rough estimate of the time it took to walk straight through and does not account for the resident possibly stopping along the way. According to the Administrator's time line, the Resident exited the building at 6:00 PM which means she would have started her journey prior to that and no staff member observed her pulling up a chair to the fence, hopping over the fence cordoning off the Memory Care Unit, walking down the walkway past the AL dining room, walking through the courtyard door access to the activity room, walking through the activity room, walking out the interior hallway door of the activity room, turning right and walking down the AL hallway until she reached the west alarmed exit door, pushed down the door handle and exited the building. Resident #1 managed to walk this route without any of the evening staff observing her along the way.

On at 1:00 PM, Resident #1 was observed standing outside the front lobby with 4

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A 025	Continued From page 18 Emergency Medical Technicians (EMT) in front of an ambulance. One EMT was heard to ask Resident #1 if she could get on the stretcher to which Resident #1 stated "Yeah, let's go" and she hopped on the stretcher. The EMT buckled the resident on the stretcher and they put her in the ambulance and drove off. An inquiry was made to the LPN Charge Nurse as she was walking by where and why were they taking Resident #1, to which she stated Resident #1 had increasing agitation, she was trying to climb over the fence. She stated she called the physician and got an order to send to the resident to the hospital for evaluation and she will probably go to the (Name of a , , facility associated with the local hospital). Resident #1 was observed to be calm, not agitated and compliant with direction when she was taken away in the ambulance by the EMTs. Review of Resident #1's clinical record revealed a Resident Observation Log entry by the LPN Charge Nurse dated at 1 PM documenting, 'Resident observed shaky and extremely agitated attempting to jump gate. Doctor notified and ordered to send resident out to ER (Emergency Room) for evaluation.' On at 3:00 PM, an interview was conducted with Medication Technician Staff C who stated he knows Resident #1 well, further stating all you have to do is turn your and she is gone. On at 3:05 PM, an interview was conducted with Resident Assistant Staff D who stated it is very stressful to work on the Memory Care Unit further stating there are only 2 working the night shift for the whole building. Resident Assistant Staff D confirmed there is only one	A 025		

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person working on the Memory Care unit per shift who is responsible for looking after and watching all the residents. She stated Resident #1 is always walking. She stated she was working that evening in the Memory Care Unit when Resident #1 got out and she was putting people to bed around 6 PM, stating Resident #1 goes to bed last. She stated Resident #1 must have seen her putting residents to bed and she decided to skip. She stated she was in a resident's room with the door closed and the resident realized it was clear. She stated it was around 6:30 PM to 7:00 PM that they started looking for her but she was already gone. She stated she did not hear any alarms going off, she must have been too far away to hear. She stated Staff A came to her and said where's Resident #1 and I said she was sitting on the patio. There were only 3 staff on that evening. They searched room to room and she stated she drove her car around about 7:30 PM but she did not see her, it was dark, stating she could have been gone for about an hour at that point. She stated about 8:00 PM or 8:30 PM when the Administrator came he called the police. Police (Department A) brought her . . . around 10:30 PM. The Owner sent her to the hospital and she came after her shift was over. An inquiry was made if she was aware Resident #1 was sent to the hospital for evaluation at 1:00 PM today, to which she stated nobody told her about that.

On . . . . . at 10:00 AM, an interview was conducted with the Administrator who provided the Elopement drill in-service that was conducted on after the elopement of Resident #1. There were 11 staff names listed to include the Administrator who conducted the in-service. Staff D, who was working on the Memory Care unit on the evening of the elopement on and

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A 025	Continued From page 20 who should have been providing supervision of Resident #1, was not listed as a participant in the elopement drill conducted on . The Administrator confirmed this was the only elopement in-service conducted after the elopement event on . Review of the facility staffing roster revealed there are 27 employees listed, 17 of which did not participate in an elopement drill after Resident #1's elopement event on . On at 10:20 AM, a tour of the Memory Care unit was conducted. 4 residents were observed seated on the patio. Resident #3 was observed ambulating around the outdoor dining area. No staff member was present. At 10:25 AM, Staff A arrived. She stated Staff B is probably helping a resident in their room. An inquiry was made what time Resident#1 came from the hospital yesterday to which she stated they sent her right , it was around 5 PM. At 11:45 AM, Resident #4 was observed to be walking up and down the walkway independently, going up to the picket fence, then to pacing and forth. On at 11:50 AM, Resident #1 was observed in the Memory Care unit walking down the walkway with her purse over her left arm. She arrived at the outdoor dining area and sat down at a table for lunch. Resident #3 was observed in the outdoor dining area and walked to the chairs by the wall and sat down. Resident #2 was observed walking down the walkway towards the door and sat down next to Resident #3. An attempt was made to interview Resident #3, however, she just stared into space. An attempt was made to interview Resident #2 and she stated she had an injury to her a while ago and she is having , but there is nothing they can do about it. An inquiry was made how long	A 025		

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she has lived here and she stated she does not remember her mind is not so good. There was no identification observed on any of the ambulatory residents. At 11:55 AM, a resident seated at a table was observed to be putting chocolate pudding into her soup. No staff were observed around at this time. 2 other residents were seated at tables for lunch. Resident #1 was up and walking. At this time, Staff B came out of and to the outdoor dining area. A resident seated at one table spilled soup all over herself. Staff B looked as to what to do as there was no other staff member around. Staff B walked through the outdoor dining area to the latticed gate and called out a persons name, however, nobody answered. At 11:57 AM, Staff A arrived and stated she will watch the residents while Staff B changes the resident's clothes. Staff B wheeled the resident away. Staff A was observed to go up to the resident who was putting pudding in her soup and she did not say anything to her or encourage her not to do that or encourage her to eat. The resident just continued to play with her food. It was noted this was the second lunch observation where the residents in the Memory Care Unit were served their lunch on disposable plates and disposable utensils. An inquiry was made to Staff A why this was and she stated since COVID they used everything disposable but about a month ago the AL side started with glass plates and silverware but she was not sure why they had not started with the Memory Care also. At 11:58 AM, Resident #1 who had been and forth came to the table, sat down, took a spoonful of soup, then up again. She was redirected by Staff A to sit down, then she was up again, left the table and walked to her room, looking at the room numbers as she was walking until she came across her room, room

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A 025	Continued From page 22 (room number). At 11:59 AM, Resident #1 came to the table now without her purse, sat down, got up and walked to her room. Resident #1 was not observed to eat her lunch and no staff encouraged her to do so. At 12:30 PM, Resident #4 was observed to be pacing and forth up and down the walkway, going up to the picket fence, then to pacing. Further observations on the Memory Care Unit on at 1:48 PM, Resident #4 was observed working with a Physical who was walking with her down the walkways. A comment was made to the Physical that Resident #4 was observed yesterday dancing to which he stated she is a good dancer and can get around. At 1:50 PM, Resident #3 was observed walking around the patio. Resident #2 was seated in a chair against the wall. No facility staff was present. At 1:55 PM, Resident #1 was observed to walk out of her room, enter a doors down from hers where Staff B was, talked to her for a second then exited that room, walked to the dining area then down towards her room when she looked at this surveyor and stated "I don't remember where I was going. She started to enter room (room number) and she was advised she lived in room (room number). She looked at the door number and said (door number), walked past that room, past the next room while saying the room numbers out loud and came to her room, saying her room number out loud and said 'This is me' and proceeded to enter her room. Resident #1 was able to identify which room was hers by identifying her room number. Observations conducted on and revealed Resident #1, Resident #2, Resident #3 and Resident #4, who are independently ambulatory, were not wearing any identification bracelet or any other form of personal identification.	A 025		

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A 025	Continued From page 23 Review of the Resident Health Assessment last updated for Resident #2 on [redacted], documents the resident diagnosis as [redacted], she receives [redacted] medications, ambulates with supervision and she is an elopement risk. Review of the Resident Health Assessment last updated for Resident #3 on [redacted], documents the resident diagnosis as [redacted] with [redacted] cognition, she ambulates independently, she requires memory care and she is an elopement risk. Review of the Resident Health Assessment last updated for Resident #4 on [redacted], documents the resident diagnoses include [redacted] and organic [redacted], she receives [redacted] medications, ambulates independently and is not an elopement risk. Resident #4 was observed to be independent with ambulation on [redacted] and [redacted] pacing the walkway [redacted] and forth and going up to the picket fence. A Health Assessment that is over [redacted] may not be reflective of the resident's current elopement status. On [redacted] at approximately 4:00 PM, the Administrator stated they are in the process of updating all the Resident Health Assessments. There was no updated Resident Health Assessment available for review for Resident #1. Resident #1 eloped from the facility on [redacted]. Observations conducted on [redacted] and [redacted] in the Memory Care Unit, revealed little to no interaction between the staff member and the residents during the lunch meal service. Residents were not encouraged to eat their meal and were not assisted with their meal. The lunch meal was served on disposable Styrofoam plates and cutlery.	A 025		

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A 025	Continued From page 24 There was no observation of any verbal interactions or communication with the residents. There was no observation of an Activities Calendar dedicated to the Memory Care Unit and no activities being conducted to engage or distract the residents whereas there were numerous activities being conducted in the AL activity room and movies being watched by the residents on the AL section of the facility. In the Memory Care Unit residents were left sitting there either by themselves or seated with another resident staring into space. As of , only one staff member continued to be assigned to the Memory Care unit with a census of 10 residents, to assist with care and activities of daily living for residents who require increased supervision related to their , . The facility advertises a secure Memory Care Unit, however, on , as a result of inadequate supervision, Resident #1 who is , , and a risk for elopement, was able to exit the facility unnoticed, was missing for approximately 3 hours walking down high traffic roads alone, during both daylight and night time hours, placing her at risk of serious injury or . 2) Review of the Resident Observation Log in the clinical record for Resident #1 revealed an entry dated documenting 'Was reported by CNA (Certified Nursing Assistant) that resident had bugs. On observation was observed. Order for (medicated shampoo to eradicate) given by doctor. CNA applied as directed to resident . .' Further review of the clinical record revealed an order from the Advanced Registered Nurse Practitioner (ARNP) dated for ' cream rinse. Wash, leave on for 10 minutes, then	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	05/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

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A 025	Continued From page 25 rinse with warm water.' Review of the Medication Administration Record revealed the treatment was rendered on . Further, there was no documentation in the clinical record Resident#1's family was notified Resident #1 had which was treated with . Review of an ARNP Clinical Note dated states under Chief Complaint, 'Patient having itching in the . Was found to have in the . She was treated for same and now feels better. The itching has improved.' There is no documentation the family was notified by the ARNP Resident #1 had and was treated for . Further review of the clinical record revealed there was no documentation of any investigation of the source of the Resident #1 came in contact with while residing on the Memory Care unit of the facility. On at 10:55 AM, an interview was conducted with the Licensed Practical Nurse (LPN) Charge Nurse in the presence of the facility Owner and an inquiry was made about the documentation in Resident #1's clinical record it was discovered she had , and if she could expand further on what transpired, to which she stated she does not remember, further stating there are 50 residents and it can't be expected that she remember everything. A second inquiry was made how a resident residing on the Memory Care unit got to which the LPN Charge Nurse stated maybe she was admitted with them. An inquiry was made if an assessment is done on admission and she stated 'Yes' then stated maybe she got it when she went out with family. An inquiry was made if Resident #1's family was notified Resident #1 had and was treated for ,	A 025		

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A 025	Continued From page 26 what investigation was done to determine the source of the and if other residents were checked for . . . . The LPN Charge Nurse stated Resident #1 was observed to have and was treated with . An inquiry was made to LPN Charge Nurse if she notified the family the resident had . . and she stated that she had. The Owner who was present for the interview piped in and stated the family was notified by the physician. An inquiry was made again to the LPN Charge Nurse if any investigation into the source of the was made to which she stated she did a . . . . check on all the residents but did not document that anywhere. She stated again she notified the family but also did not document that anywhere. On at 11:30 AM. a telephone interview was conducted with the Administrator and an inquiry made if he was aware of Resident #1 having . . and he stated he was aware about the and she was treated. He then recanted and stated 'it really wasn't . . it really was just dry . '. The Administrator stated they did a check on everyone and nobody else had . . . He stated the LPN Charge Nurse called the family, they were aware of it. On . . . . . at 12:10 PM, an interview was conducted with the Control Preventionist LPN at the nursing station who stated she called the physician about the . and got an order for the which the physician sent the prescription directly to the pharmacy. An inquiry was made as her role as the . . . . . Control nurse, if she did any tracing, any investigation, or notification to the family to which she stated the family was notified and they did not say anything. No investigation or contact tracing was forthcoming.	A 025		

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
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A 025	Continued From page 27 On . . . . . at 3:43 PM, a telephone interview was conducted with two family members of Resident #1 and an inquiry made if they were aware it was discovered on Resident #1 had . . and the . . was treated with a medicated shampoo to which they both stated they were not aware of this, they were not notified by the facility. On . . . . . at 4:00 PM, during an interview conducted with the Administrator, he was advised the family was called and were unaware Resident #1 had and was treated for . The Administrator stated, 'Oh, you called the family.' The Administrator had no further comment. Class III	A 025		