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
	AL11911749	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESERVE AT PALM AIRE (THE)	3701 MCNAB ROAD POMPANO BEACH, FL 33069

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A 000	Initial Comments An unannounced Licensure Compliant (#2021006614) and Focused Control survey commenced on and concluded on . The facility had a deficiency identified related to the Complaint (#2021006614) 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	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 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, 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 interview, the facility failed to appropriately assess and provide supervision to a resident who demonstrated signs of being an elopement risk for 1 out of 2 sampled residents, Resident#1, reviewed for elopement. The findings included: Review of the facility Resident Assessment Policy dated , documents all residents will be assessed for physical, functional, and	A 025		

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A 025	Continued From page 2 needs upon admission and with change of condition and reassessments will be conducted upon change of condition. Guidelines for Changes in Condition/Reassessment Criteria Triggers: Increased or other changes that is not ruled as or a significant shift in GEM level (Evaluation & Management). Review of the clinical record revealed Resident #1 was admitted to the facility on with diagnoses to include and Review of an Assessment and Service Plan for Resident #1 dated , documented Resident #1 with . Further, it was documented Resident #1 was unsafe to leave unescorted and has no history of attempting to leave unescorted. Review of a facility Progress Note dated at 9:38 PM, documented the front desk reported to Resident Care Director (Staff D) that Resident#1 was agitated and disrespectful and was redirected to her room. Documentation on revealed Resident #1 was very agitated and at 11:00 AM Resident #1 went out of the facility through the double doors close to the Memory Care Unit. Staff followed Resident #1 to the parking lot and called for help. Resident's family member came to get resident inside the facility. A late entry was documented on for follow up of the incident, stating the Administrator was notified of the incident and it was decided to transfer the resident to the Memory Care Unit for daycare from 8:00 AM until bedtime. Staff was made aware and Resident Care Director (Staff D) spoke to the family member and she agreed.	A 025		

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A 025	Continued From page 3 Review of a written statement given by a staff member on . . . . . regarding the incident that occurred on , documented 'Resident #1 was so agitated, I can't count the times the Front Desk called nursing to pick up Resident #1 from the lobby. I went up three times to get her. Resident #1 was supposed to stay in her apartment due to . . . . . On this day, around 12:00 PM, Resident #1 walked towards the double doors, close to the Assisted Living (AL) entrance and walked out. The doors automatically opened, and the dining server yelled out "she went out". So, I went to get Resident #1. She was walking through the parking lot, and I walked up behind her. I paid attention and followed her. I asked her where are you trying to go. She screamed and cursed "Get out of my ". I continued to walk behind her. I tried to get her to go towards the main lobby. I had my phone, so I called for the staff who was assigned to her. In the parking lot, I waved down a Private Duty Aide to come and help me. When the Private Duty Aide came to meet me, another staff person and Resident #1's family member walked up. The family member said to the resident, what are you doing? Resident #1 was so agitated she wanted to fight us. She tried to hit me with the walker, but I used my body mechanics and grabbed the walker. As soon as she saw her family member, she calmed down. I reported this incident to the Medication Technician. I did not complete an incident report because she didn't . and there were no . I followed her because she was agitated, I needed to redirect her. The family member ended up staying with her for about 2 ½ hours'. Review of a written statement given by a staff member on . . . documented 'On	A 025		

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A 025	Continued From page 4 . . . . . , when I was sitting in the breakroom, staff saw Resident #1 outside. Staff went over to catch her. She said she is not going . . . to her room. She was very aggressive. She said she was looking for her car. I motioned for a staff member to help me. I was in front of the walker and another staff member was behind her trying to stop her from going toward the road. Resident#1 was tired and lost her balance. Staff held on to her and helped slide to the floor. Later, the Dietary Manager came and convinced Resident #1 to get up. The Dietary Manager assisted her into her wheelchair and took her to her apartment. I reported to the Medication Technician'. Review of the resident's record revealed on , the Resident Care Director attempted to implement 'day trips' to the facility's Memory Care unit from 8 AM to 8 PM. Additionally, discussions were being held with the family regarding moving the resident from the general AL side of the facility, to the Memory Care side of the facility. Further review of the resident's record revealed no medical or social evaluation or assessment into the resident's increasingly and aggressive behaviors and no measures implemented to ensure Resident #1 remained safe from 8 PM to 8 AM while she was not doing the 'day trips' in the Memory Care unit. Review of the Agency for Health Care Administration Resident Health Assessment form dated , revealed Resident #1 has a medical history of and ; she requires direction orientation; is independent with all activities of daily living (ADL), and requires standby supervision with bathing and grooming. Resident #1's and behavioral status was alert and	A 025		

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A 025	Continued From page 5 oriented to self. Nursing Treatment/ Service Requirements revealed an admission to Hospice care to coordinate with nursing services and provide assistance with ADLs. Resident#1 was not identified as an Elopement Risk. Documentation on at 12:34 PM, states Resident #1 was observed in the AL nursing station at approximately 8:30 PM on . During the 9:00 PM room round checks, Resident #1 was not observed in her room. A facility interior and exterior search ensued, and the resident was not located. Resident #1 had eloped from the facility. Review of the facility investigative report dated documented 'On , around 9:00 PM, Staff B reported to the Wellness Center that Resident #1 was not in her apartment. Staff F called the front desk and Staff A replied that she had been , around the front desk as usual, then she headed towards her apartment. All staff was alerted and went to her room. She was not there. Staff F called Resident #1's family member and asked if she was in the facility with the resident and the family member replied no and stated "I am on my way to the facility". Staff F notified the nurse on duty (Staff C) and other staff members to look for Resident #1. At around 9:30 PM, Staff F notified the Resident Care Director (Staff D), and the Resident Care Director notified the Administrator, who notified the Police. The search went on throughout the night and the resident was found on the premises outside of the building in the bushes at approximately 7:15 AM, on , by her family member. Resident#1 was transferred to (Name of Hospital); it was later reported Resident #1 was discharged from the hospital with a diagnosis of and no	A 025		

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A 025	Continued From page 6 injuries.' Resident #1 was missing from the facility for approximately 10 hours, alone, in the dark and exposed to the elements. at 1:12 PM, during a telephone interview with Resident #1's family member, she stated Resident #1 suffers with and a couple of weeks prior to the incident (on 4 separate occasions) Resident #1 was walking in the parking lot and staff had to call her to get Resident #1 to go into the facility. The family member stated they moved Resident #1 out of the facility and admitted her to a facility that has a secure Memory Care Unit due to her exit seeking and behaviors, which was a new development, as Resident #1 never had any history of exit seeking or and there had never been any issue with her going outside at night. During an interview with the Administrator on , she acknowledged the findings. Class III	A 025		