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
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 Complaint Survey for allegations set forth in Complaint #2021006186, and a Focused Control Survey, were conducted at Emerald Gardens Properties, LLC in Pensacola, FL from to . Deficient practice was identified at the time of the survey. Class I deficiencies were identified on at A0025, Resident Care - Supervision for the facility's failure to maintain a general awareness of the resident's whereabouts and A0032 - Elopement Standards for the facilities failure to complete elopement screening procedures per facility policy and failed to ensure adequate intervention were put in place to prevent elopement. The resident eloped from the facility on and sustaining a during the elopement on . The facility Administrator and Director of Nursing were notified of the Class I deficiency on at 1:28 PM. At the time of the survey the facility census was 48.	A 000		
A 025 SS=J	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	A 025		

AHCA Form 3020-0001

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

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
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 025	Continued From page 1 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 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	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 025	Continued From page 2 changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure adequate supervision to prevent the elopement of 1 of 1 (Resident #1) resident sampled for elopement. The facility's failure to appropriately supervise Resident #1 resulted in the resident successfully eloping from the building on two occasions on and . During the elopement on the resident was taken to a local hospital and diagnosed with a . This failure resulted in a Class I deficiency. The facility Administrator and the Director of Nursing were notified of the Class I deficiency on . The findings include: A review conducted of the Resident Observation Log for resident #1 revealed that on at 1:00 PM, the Director of Nursing (DON) documented, "Med tech notified me that she went to pass (illegible) 1300 (1:00 PM) medications and could not find her. Facility went into elopement search. All rooms and closets and perimeter of yard was checked, and patient was not located. ECSO (County Sheriff's Office) was called". The form goes on to state that the Administrator drove down to 72nd street to where the resident had been found and that the store staff noted the resident was " so they called (Emergency Medical Services). (The DON) and the Receptionist got on phone immediately with local hospitals and 911 dispatcher. Patient was located by 1340 (1:40 PM) at (name of hospital). The Receptionist	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 025	Continued From page 3	A 025		

called (Resident #1's) grandson to let him know what happened and was also informed that he needed to find a locked facility to move her to and also in the meantime he needed to get her an identification bracelet. He voiced understanding and said he would call APS (Adult Protective Services) case worker about placing her at a different facility."

A review was conducted of the "Patient Care Report," from the Emergency Medical Service ( ) dated . The report states the was dispatched at 1:03 PM and arrived on scene at 1:13 PM. "Dispatched to , female complaint of . Patient was walking down Lillian highway and walked into a laundromat with severe . Patient was only able to tell us her name, birthday and social security number. Patient denied any , and could not give us any other useful information." The report goes on to say, "Patient was found sitting inside convenience store. Patient was alert to person only and had a minor to on left but had no other abnormal findings ...We were unable to find any personal info in her purse as she only had what appeared to be old family photos." Transported to the hospital at 1:44 PM.

A review was conducted of the "ALF (Assisted Living Facility) Incident Report," dated for Resident #1. The times noted on the form were 12:48AM and 1:18 AM. The description of the incident stated, "Resident tried leaving property to go to her sister's." No injuries were noted. The areas to document notification to the health care provider, resident representative and law enforcement and an area to note steps taken to prevent recurrence were left blank. At the bottom of the form there was a note that stated, "Discussed with the Receptionist. She will call

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 025	Continued From page 4	A 025		

grandson about elopement system bracelet if he cannot do this, he will need to find locked unit." A review of the resident record found no corresponding observation notes and found no evidence of new interventions put in place.

A review of the Resident Observation Log dated , no time given, the DON wrote, "Resident left facility on to 75th avenue. When she was picked up by and taken to (a local hospital). (Medication Technician K) called me at 7:12 PM on letting me know she was missing. I told her to call 911 to report this and start elopement process. The Receptionist called about 15 minutes later. Let the physician know patient was at the hospital per grandson".

A review was conducted of a Law Enforcement Report of the incident on . The report stated that their Agency was informed of the incident on at 7:08 PM. The report stated, "On , I (The Law Enforcement Officer) was dispatched to 1012 N 72nd Ave, Emerald Coast Gardens Assisted Living Facility, in reference to a missing person. Upon my arrival I made contact with (Medication Technician K) who is a caretaker for the facility. (Medication Technician K) stated when she made her rounds at 5:15 PM, (Resident #1) was inside of the facility's building; however, 15 minutes later when she conducted a medical check, she realized that Resident #1 was missing. (Medication Technician K) stated a search of the facility and the surrounding grounds was conducted and (Resident #1) was unable to be located. (Medication Technician K) then stated she and several other employees got into their vehicles to search the neighboring area; however, again (Resident #1) was unable to be located. After

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 025	Continued From page 5	A 025		

completing their own search, (Medication Technician K) stated they then notified the Sheriff's Office." The report goes on to state, "While on scene with (Medication Technician K), she received a phone call from a representative at (A local hospital) stating (Resident #1) was currently at (their hospital) and had been transported there by ".

A review was conducted of the "Patient Care Report," from the Emergency Medical Service ( ) dated at 1549 (3:49 PM). The report indicated that the of a " - from standing/sitting," occurred while the resident was away from the facility. The report went on to state, "( ) responded to the named location for a type call. Upon arrival the , female patient was found , sitting on the ground, and did not appear to be in obvious distress. A verbal report of information received from the patient indicated that prior to response she tripped and scraped her and has , . The patient complains of , . Onset of symptoms was approximately 20 minutes." "The patient was found to be alert and oriented for 2 out of 4. Patient stated she has and can't remember things ... was assessed and found positive for tenderness during palpation (Putting pressure in the area) but no deformity." It is noted that this report was documented 3 hours and 23 minutes prior to Medication Technician K notifying the DON that Resident #1 was missing and 3 hours and 18 minutes prior to the notification of law enforcement.

A review was conducted of the Emergency Department provider note for the incident on . The note dated at 16:52 (4:52 PM) stated, "Complaint: The patient is a 79

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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	Continued From page 6 , female complaining of , . Chief complaint quote: TRIAGE: Presents via for , status post outside, patient is , states she has ." The report goes on to say, "The patient is complaining of left-sided , that worsens with deep breaths. The patient states that she has left and denied , ." This report is noted to be dated and timed 2 hours and 20 minutes prior to the DON being notified of the missing resident and 23 minutes before Medication Technician K reported last seeing the resident in the facility. A review was conducted of an of the completed on . The report stated, "Impression: of the left , eighth of uncertain age, suspicious for acute given the history." A review was conducted of Resident #1's AHCA Recommended Form 1823, "Resident Health Assessment for Assisted Living Facilities," dated . Under the section titled, "Medical History and Diagnoses," it stated that the resident had a history of (commonly referred to as a), hematoma (between the layers of material that cover the), with behavioral disturbances, and . Under the section titled, "Physical or Sensory Limitation," it stated that the resident could independently walk, eat get dressed and bathe. It also stated, "Makes poor decisions at times." Under the section titled, " or Behavioral Status," it stated, "Short term memory loss, alert and oriented x 0 (this means when you ask who she is she cannot tell you, she does not know where she is located, she does not know what the date and time, and she is	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 025	Continued From page 7 unaware of the situation happening around her). Under the section titled, "Special precautions," it was noted that the resident ; however, the elopement risk box was checked as, "No." Under section 1 for, "C. Does the individual have any of the following conditions/requirements?" Item number 5 read, "Require 24-hour nursing or care?" This section was blank, so it is unknown if at the time of the assessment if the resident required this. A review was conducted of Resident #1's Admission Packet dated . On page 26 of the admission Packet, titled, "Pre-Admission Elopement Risk Assessment," the form was blank. A review of the medication observation record (MOR) for revealed that Resident #1 was documented as, "Absent from home without medications," for the 2:00 PM administration of 25mg (milligrams) three times daily on . She also missed an 8:00 PM dose of the same medication for the same documented reason on along with 500mg twice per day, 50mg twice per day and 50mg twice per day. On at approximately 8:50 AM, during an interview with the Director of Nursing (DON), the DON was asked if they had and residents at risk for elopement and the DON replied, "we do not accept anyone who is an elopement risk, so we do not have any elopement risk residents at this time". She stated they had one resident (Resident #1) that eloped and her 1823 was not marked as elopement risk. When asked what they do when residents develop these behaviors after admission the DON stated that if they develop those behaviors, they would contact the	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 025	Continued From page 8 family to start the process of alternative placement. She stated they do get a GPS (Global Positioning System) bracelet or identification bracelet also. When our previous resident (Resident #1) exited the first time, we contacted the grandson. He said he would contact APS (Adult Protective Services) because they had a case worker at APS to assist them. The DON stated she called APS the second time the resident eloped because they had not received a phone call from the grandson with the first elopement. She stated they then called project lifesaver and got her a GPS bracelet. She stated they started the 30-minute log with the second elopement (. . . . .). She stated they did follow up with the grandson and requested a bracelet which he never obtained. She stated they probably should have started the log with the first elopement, but they did not. When asked if they had followed up with the grandson after the first elopement regarding the transfer process, the DON replied that the front desk staff was in contact with the grandson many times. She stated that people probably did not think she would elope again after the first one. On at approximately 1:17 PM, an interview was conducted with Medication Technician A. Medication Technician A stated that Resident #1 had eloped from the building, had been since she was admitted to the facility and thought that someone was attempting to kill her. The Medication Technician stated that the facility staff were not able to locate Resident #1 when they were passing afternoon medications on . . . . . , they looked around the property for her but were unable to locate here. Medication Technician A stated that her understanding was that the resident had eloped on the prior shift. Medication Technician A stated that after the second successful elopement	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 025	Continued From page 9 (. . . . .) the facility instituted checks on the resident every 30-minutes. Other than this intervention, there were no other interventions that she was aware of that were implemented to keep Resident #1 or any of the other residents from eloping from the facility. Medication Technician A stated that they were aware of one other time the resident eloped, but the only detail they could remember was that they believed it occurred at night. On at 2:34 PM, during an interview the DON stated that there were four incidents of Resident #1 related to elopement, with two of them being successful. The DON stated that the facility did not complete an incident report for the elopements. On . . . . . at 3:24 PM an interview was conducted with the Administrator and Director of Nursing. The DON and Administrator were asked who completed the admission packet when a new resident comes into the building. The Administrator stated that it was now done by the Receptionist and the Director of Nursing would do the double check. When asked who was responsible to ensure it was complete and accurate, they stated that they both did. They were asked how they would know if a resident posed an elopement risk. The DON stated that during the admit they would observe the resident to make a determination. She also stated that they would ask the resident's family. They were shown the "Pre-Admission Elopement Risk Assessment," and the Administrator agreed that it was not compieted. The surveyor pointed out that the 1823 stated that the resident was not an elopement risk but was marked as a . The DON stated that she talked to grandson regarding that and the grandson stated that he	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 025	Continued From page 10	A 025		

worked at a Marina and brought her there with him to work and she never away from there.

The surveyor asked if was the first time Resident #1 attempted to elope. The DON agreed. The DON stated that the Receptionist called the grandson right away to get another facility. She stated that he was told to call Adult Protective Services. She stated that they also recommended that he get Resident #1 a medical identification bracelet. She stated that they told him that they were not a locked facility and that they could not keep her on the property. The surveyor asked if there were any interventions put in place for staff to do. She stated that they put a bracelet on her with the name of the facility and its location and contact information. She further stated that they did not start 30 minute checks after the elopement on the . When asked if a root cause analysis was completed on the events, they were unable to produce any evidence of a full investigation into the elopements of this resident.

On at approximately 12:34 PM, a follow up interview was conduct with the DON during which she was asked about the Resident #1's elopement on . The DON stated that Med Tech K provided authorities and facility leadership inaccurate information regarding the time Resident #1 went missing. The Med Tech K stated the resident was in the building at around 5:00 PM, but in fact Resident #1 had already eloped and was at Baptist Hospital before 5:00 PM. Resident #1 was not present at dinner and had already eloped from the facility. Per the DON, Med Tech K made a false statement. The DON stated the Med Tech K was no longer at the facility. She was terminated from employment at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 025	Continued From page 11 their facility. The DON further stated that the resident likely went out the front gate of the facility and down the street. She was found at the store. When asked the name of the store, the DON replied she was unaware, but it was just to the left of the stop sign. The store was observed to be a Shop and Save Food store which was 0.3 miles from the facility on Lillian Highway. had picked up Resident #1 inside the store and transported her to Baptist Hospital. A review of the facility policy titled, "Administrative Policy Missing Resident," no implementation or review dates were noted. The policy stated on the second page, "It is the policy of this facility that an elopement risk assessment is completed as a part of pre-screening as well as upon admission. On a quarterly bases all residents will be assessed for elopement risk or as necessary." Class I	A 025		
A 032 SS=J	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	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 032	Continued From page 12	A 032		

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. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 032	Continued From page 13 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 interview and record review, the facility failed to complete elopement screening procedures per facility policy and failed to ensure adequate interventions were put in place to prevent elopement for 1 of 1 (Resident #1) residents sampled for elopement. The facility's failure to screen Resident #1 for elopement and appropriately supervise Resident #1 resulted in the resident successfully eloping from the building on two occasions on . . . . and . During the elopement on . . . . . the resident was taken to a local hospital and diagnosed with a . This failure resulted in a Class I deficiency. The facility Administrator and the Director of Nursing were notified of the Class I deficiency on . . . . . . The Findings Include: A record review conducted for resident #1 revealed the Agency for Health Care Administration (AHCA) form 1823 dated . . . . . At the time of completion, the resident had a history of . . . . . with . . . . . (commonly referred to as a . . . . .), ... and . . . . . . She was noted to make poor decisions at times, had short term memory loss and was alert to name only. Under the section titled, "Special	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 032	Continued From page 14	A 032		

precautions," it was noted that the resident ; however, the elopement risk box was checked as, "No." She required daily checks for wellbeing, whereabouts, and reminders for important tasks. A review of Resident #1's Admission Packet, dated , noted that on page 26, a form titled, "Pre-Admission Elopement Risk Assessment," was blank.

Further review of the record revealed the resident had eloped the facility on two occasions the first being on when Emergency Medical Services ( ) were dispatched at 1:03 PM to a laundromat off Lillian highway for a severely female (Resident #1). The Medication Technician had been unable to find the resident for her 1:00 PM, medications and notified the Director of Nursing (DON), per the Resident Observation log dated . The staff conducted a search of the facility and after calling the local hospitals were able to locate the resident. The grandson was notified and was informed he needed to start looking for a locked facility and also needed to purchase an identification tag for the resident.

Record review found no facility elopement assessment completed after the elopement for Resident #1, nor was a new 1823 assessment form completed to reassess the resident's elopement risk.

The second elopement occurred on when was dispatched at 1549 (3:49 PM) to 75th avenue for a " ". The report stated the resident was and sitting on the ground, reporting she had tripped and scrapped her . The report documented Resident #1 was positive for tenderness during palpation (putting pressure in the area) but no deformity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 032	Continued From page 15 She was transferred to a local hospital and was triaged at 1652 (4:52 PM) where an , report stated, "Impression: of the left , eighth of uncertain age, suspicious for acute given the history." The record also revealed that the resident had attempted to elope on . A review of the "ALF Incident Report," dated for Resident #1 revealed that at 12:48 AM and 1:18 AM, "Resident tried leaving property to go to her sister's." No injuries were noted. The areas on the form to document notification to the health care provider, resident representative and law enforcement and an area to note steps taken to prevent recurrence were left blank. At the bottom of the form there was a note that stated, "Discussed with the Receptionist. She will call grandson about elopement system bracelet if he cannot do this he will need to find locked unit." A review conducted of the facility's Fire and Elopement Drills which revealed no elopement drills had be conducted since the resident's elopements on or with the last documented drill being on at 10:05 AM. An interview conducted with the Administrator on at 10:00 AM, revealed the facility conducted fire and elopement drills at the same time. A review of the training records for the 2 staff members working on when resident #1 eloped was conducted. The review revealed that staff member H, a Medication Technician (Med Tech), had a hire date of . Med Tech K, who reported to the DON that the resident was missing at 7:15 PM, had a hire date of , and did not have documentation of having received elopement response training,	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 032	Continued From page 16 Facility Emergency procedures or of incident reporting training. On at approximately 8:50 AM, an interview was conducted with the Director of Nursing (DON), who stated, "We do not accept anyone who is an elopement risk, so we do not have any elopement risk residents at this time". She stated they had one resident that eloped (Resident #1) and her 1823 was not marked as elopement risk. The DON stated that if a resident developed those behaviors after they are admitted, the facility would contact the family to start the process of alternative placement. She stated they would get a GPS bracelet or identification bracelet. When our previous resident exited the first time, we contacted the grandson. He said he would contact APS (Adult Protective Services) because they had a case worker at APS to assist them. The DON stated she called APS the second time the resident eloped because they had not received a phone call from the grandson with the first elopement. She stated they then called project lifesaver and got her a GPS bracelet. She stated they then started the 30-minute log with the second elopement on . She stated they did follow up with the grandson and requested a bracelet which he never obtained. She stated they probably should have started the log with the first elopement on , but they did not. Asked if they had followed up with the grandson after the first elopement regarding the transfer process. The DON stated that the front desk staff was in contact with the grandson many times. She stated that people probably did not think she would elope again after the first one. On at approximately 3:24 PM, an interview was conducted with the Administrator and Director of Nursing. The DON and	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 032	Continued From page 17 Administrator were asked who completed the admission packet when a new resident comes into the building. The Administrator stated that it was now done by the Receptionist, and the Director of Nursing would do the double check. The DON stated that she would initially make a determination if the prospective Resident was appropriate for admission. She also stated that the Receptionist did follow a checklist for the Resident Admission. When asked who was responsible to ensure it was complete and accurate, they stated that they both did. They were asked how they would know if a resident posed an elopement risk. The DON stated that during the admit they would observe the resident to make a determination. They were shown the "Pre-Admission Elopement Risk Assessment," for Resident #1 and the Administrator agreed that it was not completed. The surveyor asked if . . . . . was the first time Resident #1 attempted to elope. The DON agreed. The DON stated that the Receptionist called the grandson right away to get another facility. She stated that he was told to call Adult Protective Services. She stated that they also recommended that he get Resident #1 a medical identification bracelet. She stated that they told him that they were not a locked facility and that they could not keep her on the property. The surveyor asked if there were any interventions put in place for staff to do. The Administrator responded that they had to call the . . . . hotline to get a GPS bracelet. She stated that they also tried to put an alarm on the doors, but it would have just gone off constantly because they have a lot of residents that go in and out all day. She stated that the doors do not have alarms. She said that there was an alarm system,	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 032	Continued From page 18 but it was more like a home security alarm. She stated that the doors are locked at 7:00 PM, every night, but it keeps people out of the building, not in it. She stated that they completed an incident report for the elopement attempt. The DON stated that she thought the GPS device would have a perimeter alarm that would set it off if Resident #1 went beyond it. She stated that after the fact she found out it would just alarm if she got out of the gate, they could ping the bracelet to find her location. She stated that they put a bracelet on her with the name of the facility and its location and contact information. She said that Search and Rescue came out about 3 days later to put on the GPS bracelet. She said that she told the staff that they had to lay on Resident #1 every 30 minutes. When asked she confirmed that they did not start 30-minute checks after the elopement on the . The surveyor and asked if either of the 2 elopement incidents had been reported to the State Agency. They stated that neither had been reported. When asked if a root cause analysis was completed on the events, they were unable to produce any evidence of a full investigation into the elopements of this resident. The surveyor asked what the facility had done to ensure this does not happen again. The Administrator stated that they were seeing residents to on a daily basis. She stated that they discuss any changes thoroughly and speak to the doctor and that they just watch for those behavioral changes. The DON stated that staff were on a constant lookout for symptoms (older individuals are at an increased risk of significant when they have a). She stated that	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 032	Continued From page 19 staff come to her to let her know that something doesn't seem right with the resident and any changes in behaviors. She stated that the staff know their residents. A review of the facility policy titled, "Administrative Policy Missing Resident," no implementation or review dates were noted. The policy stated on the second page, "It is the policy of this facility that an elopement risk assessment is completed as a part of pre-screening as well as upon admission. On a quarterly bases all residents will be assessed for elopement risk or as necessary." Class I	A 032		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1)Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of	A 081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 081	Continued From page 20 completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of	A 081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 081	Continued From page 21 compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty	A 081		

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
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 081	Continued From page 22 (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on interview and staff education file review the facility failed to ensure all required education was completed for 2 of 7 (Medication Technicians K and H) staff education files reviewed. The findings include: A review was conducted of employee education for Medication Technician K,who had a date of hire noted as . At the time of the review the surveyor was unable to locate education for Pre-service Orientation, Elopement Response Training, Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures and Incident Reporting Training. The administrator was made aware that the surveyor was unable to locate these required staff education documents on at 2:34PM. She came minutes later with a stack of education documents. These education documents were not located in the stack given. A review was conducted of employee education for Medication Technician H,who had a date of hire noted as . The employee record review, the following training elements were	A 081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 081	Continued From page 23 missing: Job Description, pre-service orientation, elopement training, reporting major incidents, [redacted]. A list of missing training was provided to Administrator and DON. No additional documents were provided to the surveyors prior to exit. On [redacted] at 3:24 PM, an interview was conducted with the Administrator. When asked who was responsible for ensuring staff received the required education, the Administrator stated that the Receptionist was the one that did all of the new employee paperwork. The Administrator stated that the Receptionist has new employees complete the tests for understanding of the education and then she would have the Administrator print certificates for the staff. The Administrator was then asked who was responsible for checking behind the Receptionist to ensure all of the requirements were met. The Administrator stated that it was her responsibility to do so but had not been doing that because the Receptionist had been completing everything perfectly.	A 081		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 165	Continued From page 24 quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency ' s online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency ' s online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 165	Continued From page 25 of the facility ' s investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section.	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 165	Continued From page 26 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to complete and submit a 15-day Adverse Incident report to the State Agency for two resident elopements (and), for 1 of 1 residents reviewed for Adverse Incidents, Resident #1. The findings include: On an offsite review of the State of Florida Adverse Incident Reporting system found no Adverse Events reported by the facility since . A record review was conducted for Resident #1 which revealed the resident had eloped the facility on two occasions the first being on when Emergency Medical Services ( ) were dispatched at 1:03 PM to a laundromat off Lillian highway for a severely female (Resident #1). The Medication Technician had been unable to find the resident for her 1:00 PM medications and notified the Director of Nursing	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 165	Continued From page 27 (DON), per the Resident Observation log dated . The staff conducted a search of the facility and after calling the local hospitals were able to locate the resident. The grandson was notified and was informed he "needed to start looking for" a locked facility and also needed to purchase an identification tag for the resident. The second elopement occurred on when was dispatched at 1549 (3:49 PM) to 75th avenue for a " ". The report stated resident #1 was and sitting on the ground, reporting she had tripped and scrapped her . The report documented Resident #1 was positive for tenderness during palpation (putting pressure in the area) but no deformity. She was transferred to a local hospital and was triaged at 1652 (4:52 PM) where an , report stated, "Impression: of the left , eighth of uncertain age, suspicious for acute given the history." On at approximately 12:45 PM, an interview was conducted with the Administrator, during which the last 3 adverse incident the facility had submitted to the state agency were requested. The Administrator responded that she has never submitted an adverse incident. Asked if she reported either of the elopements of Resident #1. She stated that she did not. She went on to state her understanding of an adverse incident is something that you could have prevented but still happened. She stated she is only aware of one elopement and that was the most recent on . She stated that APS (Adult Protective Services) was called on that elopement. At this time the administrator was asked if any Adverse Incident was filed with the state agency in addition to notification of APS. The Administrator said they did not file an	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 165	Continued From page 28 Adverse Event with the state. A review was conducted of the facility policy, "Adverse Incident Reporting," with no effective or last reviewed date. The policy stated, "The One-Day Adverse Incident Report must be submitted within on business day after the occurrence of the incident. The 15-Day Adverse Incident Report must be submitted within 15 days of the occurrence of the incident. Submission of both reports is require (this part was underlined)." The policy then goes on to pose questions to help staff determine if the event required a report to be filed. It stated: Question 1: Did the incident occur in which the resident was injured or a specific situation existed? Reportable injuries/situations are: Elopement (as defined by the facility) AND Question 2: Is the incident in which one or more of the injuries listed above occurred, an event over which the facility's staff could have had (prevented or influenced the occurrence or extent of injury to the resident)? AND Question 3: Is the incident on which one or more of the injuries listed above occurred, an event that is associated completely or partly with the staff's intervention and not the result of a pre-existing condition that the intervention was trying to correct or control? If the answer to 1, 2, and 3 is YES begin the internal investigation of the incident and submit the completed One-Day Adverse Incident Report to the Agency for Healthcare Administration." The policy went on to stated, "If the answer to Questions 2 and 3 cannot be answered within one business day, begin the internal investigation of the incident and submit the completed One-Day Adverse Incident Report to the Agency	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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 165	Continued From page 29 for Healthcare Administration." Class III	A 165		
CZ000	Initial Comments An unannounced Complaint Survey for allegations set forth in Complaint #2021006186, and a Focused Control Survey was conducted at Emerald Gardens Properties, LLC in Pensacola, FL from to Deficient practice was identified at the time of the survey.	CZ000		
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic , submission to	CZ814		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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
CZ814	Continued From page 30 the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; ... ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on interview and records review, the facility failed to ensure all employees employment status was updated within 10 business days within the Background Screening Clearinghouse Roster for 1 of 6 (Patient Care Assistant D) employees reviewed. The findings include: On , a review was conducted of Patient Care Assistant D, with a hire date of ... , to review for inclusion of the Background Screening Clearinghouse Roster. At the time of review, Patient Care Assistant D was not listed on the Background Screening Clearinghouse Roster. On at 12:30 PM, during an interview the Bookkeeper stated, "When I receive the background ... that is when I put them on the roster." The Bookkeeper was not aware of the timeframes for being added to the roster. Unclassified	CZ814		
CZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes	CZ830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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
CZ830	Continued From page 31 and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider:	CZ830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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
CZ830	Continued From page 32 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.	CZ830		

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
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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
CZ830	Continued From page 33	CZ830		

This Statute or Rule is not met as evidenced by:
Based on review of the Emergency Status System (ESS) reporting and staff interview, the facility failed to report in the ESS system daily.

The findings include:

On , an offsite review of the ESS system conducted for the facility indicated that there was no Census and Available Beds reporting in the ESS system from until . Additionally under the section entitled, "COVID-19 (Coronavirus 2019) Monitoring: Additional Info" the facility was inconsistently reporting during this timeframe. For the Month of , , 2021, the facility reported on 9 out of 30 days. For the month of , the facility reported on 11 out of 31 days, for , it was 12 out of 28 days and for , they reported on 16 out of 31 days.

During the Focused Control survey on at approximately 12:00 PM, the Administrator was asked who was responsible for reporting in ESS. The Administrator stated she was, but she had turned some of those duties over to the receptionist. The Administrator was asked to pull up ESS to review the daily reporting entries. The ESS system was reviewed with the Administrator, and reporting gaps were found. There was no Census and Available Beds reporting listed between the dates and - almost 4 months. The Administrator stated she has been submitting and doesn't understand why it isn't there. She showed strings of ESS from previous months that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967671	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD GARDENS PROPERTIES, LLC	1012 N 72 AVENUE PENSACOLA, FL 32506

(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
CZ830	Continued From page 34 had no gaps, but concurred that they had not reported daily. The Administrator reported that she was aware of the daily reporting requirement and that there should not be gaps. On . . . . . at 1:08pm a call was placed to the Assisted Living Unit for ESS information. The representative stated that it looked like what the facility did was, since the census didn't change, they didn't hit save on any entries they may have made. The representative stated that there were more entries in Additional 1 section. On . . . . . at 1:15 PM, during an interview the Director of Nursing (DON) stated that the Administrator was doing the updates to ESS, but it was then given to the Receptionist to complete. The DON stated that she showed the Receptionist the correct way to do it. She was told to click the event tab and update and that was all. She was not aware of the missing data. The DON stated that she told the Receptionist this morning that it was a problem and that she needed to go through every single tab and click save. Class III	CZ830		