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
	AL11969434	A. BUILDING: _____ B. WING _____	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF WELLINGTON CROSSING	8785 LAKE WORTH ROAD WELLINGTON, FL 33467

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A 000	Initial Comments An unannounced complaint investigation Complaint number #2021008395, was conducted in conjunction with a Focused Control and Generator assessment survey at Harborchase of Wellington Crossing on through . The facility had a deficiency identified at the time of the survey related to the complaint.	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 observation, record review and interview, the facility failed to ensure that a system was in place to prevent elopement for one of 11 residents residing in the Memory Care Unit identified as an elopement risk, Resident #1, as evidenced by failing to implement identification on the persons of residents determined to be at risk for elopement, and establish a system to facilitate easy recognition of residents at risk for elopement by all employees.	A 025		

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A 025	Continued From page 2 The findings included: Review of an investigative summary completed by the facility revealed on a group of individuals that visited their family members residing in the Memory Care Unit (MCU) of the facility was getting ready to leave after completing their visit. However, there was no one at the front desk as usual to let them out. The Concierge was to be watching the monitor to see who is entering and leaving the MCU unit and buzz them in and out as needed. Subsequently, one of the visitors asked one of the Employees of the MCU, a Certified Nursing Assistant (CNA), to let them out. As the visitors were leaving, one of the residents, Resident #1 unidentified at the time, seized the moment and left the MCU with the visitors, without the CNA noticing. Resident #1 exited the facility on without anyone in the facility realizing the resident had eloped from the MCU. This writer traveled the roads Resident #1 walked to reenact the distance and possible dangers Resident #1 would have been exposed to when she eloped from the facility. After exiting the facility at 6:08 PM, she would cross the driveway and a large pond with a floating fountain, before reaching the sidewalk that runs parallel (east/west) to the main six lane road adjacent to the facility. The pond is down a grassy slope and does not have any barriers to prevent entry. Then, Resident #1 would have walked approximately a quarter mile west alongside a preserve that is partially barricaded on the west end and unprotected on the east side. After reaching the west side of the sidewalk that intersects another street extending north/south near a gas station, Resident #1 would have crossed the two-lane road going north/south. From the west side corner, she would then cross	A 025		

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A 025	Continued From page 3 the major six lane road to south. After crossing the six lane-road, Resident #1 would walk one mile south to where she was found. However, before reaching her destination, Resident #1 would have walked on multiple uneven surfaces, crumbling pavement, seventeen minor intersections leading to the surrounding residential communities (gated and non-gated), a few bushy areas by the sidewalk and two canals. The streets in either direction are heavily traveled with a posted speed limit of 45 miles per hour. Traversing these sidewalks and roadways alone at night placed Resident #1 at risk for sustaining harm to include injury or . Review of Resident #1's record revealed she was admitted to the facility on . Review of the Resident Health Assessment (AHCA Form 1823) dated , revealed the following diagnoses: communication ; ; Major ; , ; , and difficulty in walking. The record revealed the resident is alert but forgetful. It further documented Resident #1 required one person supervision for ambulation, bathing, , self-care grooming, toileting, and transferring. Resident #1's wellbeing and whereabouts were to be monitored daily. On at 10:56 AM, this writer conducted a tour of the MCU. The unit is located on the west side of the facility and occupies two floors. To gain access to the unit, the Administrator keyed in a code on the electronic door keypad to grant access. The Administrator stated to enter or leave the MCU, an employee with an access card must either swipe their card or press the code number. The Administrator stated that a staff member who provides direct care should have been able to differentiate and identify a resident from a visitor.	A 025		

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A 025	Continued From page 4 On at 11:37 AM, an interview was conducted with Resident #1 during which she stated her reason for leaving the facility was to visit her son. She reported that she pushed the door and left. She said there was no code needed. It was observed that Resident #1 had no identification on her person at the time of the interview. On at 11:40 AM, an interview was conducted with CNA Employee A who stated they usually have four CNAs per shift, two CNAs on the first floor and two on the second floor, and one Medication Technician for both floors. She stated the residents do not wear bracelets to identify them as elopement risk. She stated she was aware of one more resident who was an elopement risk, but he is hospitalized. On at 12:49 PM an interview was conducted with the Administrator who stated that after she had reviewed the video footage of Resident #1's elopement, she confirmed that an employee from the MCU had opened the MCU door to let some visitors out at 6:08 PM. Resident #1 joined them and left the facility at the same time. She also reported that there was no one at the front desk at that time. She also stated that Resident #1 was brought to the facility by her son and the local police Sheriff on the same day of at 9:18 PM. The Administrator stated they have implemented corrective actions after Resident #1 eloped on to include conducting in-services for all staff to identify everyone exiting the MCU to make sure they are not residents attempting to leave and as of providing all residents identified as an elopement risk with an identification bracelet. Resident #1 was absent from the facility for	A 025		

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A 025	Continued From page 5 approximately 3 hours without anyone at the facility realizing she was missing. On at 11:54 AM an interview was conducted with the MCU Director who stated Resident #1 usually walks a lot in the evening, going up and down in the elevator and socializing with the other residents of the MCU on the first floor. Resident #1 ambulates independently and goes to the elevator by herself. When asked why the residents are allowed to go into the elevator unsupervised, the MCU Director said the residents are in a locked secured environment. The MCU Director stated residents are not restricted to go wherever they want to, as long as it is in the confines of the secured environment, stating there is a patio upstairs that the residents can go to. He stated when they go to the patio, the staff always monitor them both in person, and on the camera located at the front desk. He stated the staff at the front desk are on duty until 8:00 PM. During lunch observation on at 12:00 PM, it was noted only one resident who is supposed to wear a wristband had one on at her ankle. All the other residents had none. The MCU Director stated when questioned on that issue that "they are constantly putting on bracelets on those residents", however, "they keep on taking them off". At 12:05 PM on , Resident #1 was observed without her bracelet and was questioned about it. She stated they put the bracelet on me to indicate that I am a high elopement risk. She said "I am not an elopement risk. When I want to go out, I just want to go. I do not want people to stop me".	A 025		

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A 025	Continued From page 6 On . . . . . at 1:33 PM, an interview was conducted with a family member of Resident #1 who stated she had informed the Administrator that Resident #1 would try to elope from the facility anytime she finds an occasion to do so. She said Resident #1 has done it before at another facility. They agreed that it would be best to put her upstairs to prevent occurrence of this behavior. The family member stated that is the reason why Resident #1's room is located away from the elevator on the north end of the MCU. The family member stated Resident #1 lived in the surrounding neighborhood for over thirty years and is very familiar with the area, however, when she left the facility to go to her previous home, she missed the street. She stated the house is approximately a mile away from the facility. On at 5:27 PM, an interview was conducted with Receptionist Employee B who was working at the front desk the evening Resident #1 eloped from the facility. She stated she usually works from 2:30 PM to 8:00 PM. She stated one of her assigned duties is monitoring who goes in and out of the facility. She stated there is a sign-in book for the Memory Care and one for the Assisted Living (AL). Visitors and family members are required to sign in and sign out. She said there was also a book to identify residents who are not supposed to come out of the Memory Care. She further stated she would have recognized Resident #1 if she was at the front desk when Resident #1 walked out of the MCU as she knows her very well. She stated at the time Resident #1 exited the front door, she was not stationed at the front desk and was assisting another resident at the time. Employee B confirmed it was not possible to view the front desk from where she was assisting another	A 025		

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A 025	Continued From page 7 resident. She stated she was informed about Resident #1 missing after it happened when she received a call from the Executive Director asking where she was when Resident #1 left the building. She said she did not know anyone was missing. On at 5:51 PM, an interview was conducted with Licensed Practical Nurse (LPN) Employee C who stated it was her first time working on the evening shift of 3:00 PM to 11:00 PM. She reported there are two residents that she is aware of that are at risk for elopement. The residents are Resident #1 and another male resident (identified by name). Employee C reported the male resident is continuously exit seeking but he has not yet eloped from the facility. Review of the MCU records for potential elopement risk individuals, revealed there were 11 residents meeting the criteria for at risk for elopement, however, Employee C was only aware of two. Review of the elopement training conducted by the facility on titled Doors and Keeping Residents Safe, revealed LPN Employee C was not present. In the Elopement Drill conducted on at 7:00 PM, Receptionist Employee B was also not present. During an interview conducted with CNA Employee D and CNA Employee A, on at 6:39 PM, Employee D stated on the evening of , right after dinner, Resident #1 had eloped from the facility. Employee D stated she and her co-worker were assigned to care for the 25 residents who reside on the second floor of the MCU and were getting residents ready to go to bed when the elopement	A 025		

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A 025	Continued From page 8	A 025		

occurred. Employee A stated Resident #1 who is independent, alert, and oriented, often remained in the common areas of the unit to watch television or visit with friends on the first floor after dinner. Employee D stated they were not aware Resident #1 had left the facility until it was reported to them.

During a follow-up interview conducted with the MCU Director on at 6:00 PM, he stated Resident #1 usually went downstairs to the courtyard or to socialize with her friends and she was already on the first floor when she left the facility on . He stated when visitors come to the facility, they sign in and sign out at the front desk when they leave. When they are leaving, an employee, usually a CNA, must use their key card to let them out. The MCU Director said CNA Employee E was not familiar with Resident #1, but all employees know that they must first check to see who they are letting out of the MCU. The MCU Director said Employee E was never assigned to work with Resident #1 however, she should have been familiar with Resident #1 because Resident #1 went down to the first floor very often. Further, the MCU Director stated that their resident to staff ratio was usually 8:1. The census on the MCU on when Resident #1 eloped from the facility was fifty-one residents with two employees on each floor. Therefore, the staff ratio for that day was 12.75 or 13 residents per employee. He stated they are now rotating staff more often, at least once a week to increase staff familiarity with all the MCU residents. He stated they are making sure that every staff member is familiar with all the residents in the MCU, and they must screen everyone before letting them out.

On at 8:57 AM, a telephone interview

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A 025	Continued From page 9 was conducted with another family member of Resident #1 stating he went to visit with Resident #1 at the facility at around 7:15 PM, however, when he got to the Resident's door, it was locked. He stated one of the employees on the second floor opened the door, but they did not find Resident #1 in the room, so they searched upstairs but did not find her. The family member stated he decided to leave stating Resident #1 usually went down to the first floor to meet with her friends, and he did not want to disturb Resident #1. However, later that evening the family member was contacted by the local police and was told Resident #1 was found the streets a mile and half away from the facility. On at 12:27 PM, a telephone interview was conducted with CNA Employee E who stated she was not familiar with the resident who eloped as she normally works on the first floor and knows those residents and Resident #1 resided on the second floor. She stated on that evening a resident who requires a two person assist for transferring requested to get into bed and while she was waiting for her co-worker to assist, a visitor approached and asked her to let him out of the MCU. She stated when she got to the door, she saw 4 people standing there, in addition to the man who came to look for her. As soon as she swiped her card to let the visitors out, she left and went to assist the other resident with her co-worker. Employee E further confirmed Resident #1 did not have an identity wristband, otherwise she would not have let her leave. Review of the Facility's Elopement Policy reflected all necessary precautions to be taken to prevent elopement of residents from the MCU. It stipulates that:	A 025		

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A 025	Continued From page 10 When a door that is alarmed has been accessed by using a swipe badge, it takes 15 seconds to reactivate. During those 15 seconds, an associate needs to stand at the door until the green indicator light turns on. There is a timed delay until the door is once again secure after someone has gone through the door. Interviews were conducted with multiple individuals who confirmed they were not aware of the time delay for the alarmed doors to be re-alarmed. On at 12:32 PM, LPN Employee F, who has been working at this facility for nearly three months, both in the MC and in the AL, stated she was not aware of any time delay for the alarmed doors. She also stated she is not familiar with any of the residents who are at risk for elopement, further stating she has never seen any residents wearing an identification . The MCU Director stated during an interview conducted on at 1:00 PM, that the doors do not emit any audible sounds, but if left opened for too long, an electronic message is automatically sent to their radios. He also reported that they have trained all staff to make sure that the MCU doors are fully locked when entering and leaving the MCU. He said that he was not sure how long it takes for the doors to be 're-alarmed', he added maybe a second. He stated that once the doors are magnetized in locked position, they can only be reopened by using the swipe card. The failure to ensure that all employees who work in the MCU are fully trained to recognize and identify residents who are at risk for elopement resulted in the elopement of one of their residents, Resident #1. Resident #1 was allowed to go downstairs to the first floor of the MCU	A 025		

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A 025	Continued From page 11 using the elevator by herself and allowed to roam about the first and second floors of the MCU alone even though her health assessment screening documented she required one person supervision at all times. This lack of supervision potentially contributed to the elopement of Resident #1 and placing her in harms way being alone the streets at night. Further, Resident #1 and other residents identified as a high risk for elopement do not have any identification on their person to identify their potential for elopement attempts. During a final interview with the Administrator on at 2:00 PM, the Administrator could not provide evidence of her monitoring the effectiveness of the implemented safety measures following the elopement of Resident #1. She stated she will from now on conduct random checks and audits on a weekly basis, to ensure that employees are following the guidelines. Class III	A 025		