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
	AL11911654	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OPAL AT CAPE CORAL	4920 VICEROY COURT CAPE CORAL, FL 33904

(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 relicensure and complaint survey for #2021011365, #2021013162, and #2021013562 was conducted through at The Opal at Cape Coral, an assisted living facility in Cape Coral, Florida. Complaint #2021011365 was substantiated at A0025, A0165, A0032, A0079, A0030 and A0056. Complaint #2021013162 was substantiated at A0025, A0165, A0032, A0079, A0030 and A0056. Complaint #2021013562 was substantiated at A0025, A0165, A0032, A0079, A0030 and A0056. Deficiencies A0025 - Resident Care - Supervision, A0032 Resident Care - Elopement Standards, and A0079 Staffing Standards were determined to be Class 1 level which placed residents in Imminent Danger. The following is a description of the deficiencies. .	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 and must assist in making for the necessary care and services to treat the	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 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 Resident Care Standards. 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 changes that resulted in the provision of additional services.	A 025		

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A 025	Continued From page 2 This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to provide care and services appropriate to the needs of residents in the memory care unit, failed to maintain a general awareness of the resident's whereabouts, and failed to maintain a written record of any significant changes for 1 (Resident 12) of 1 resident reviewed for elopement. Failure to provide adequate supervision allowed the resident with to elope from the secured unit, and ended up in a canal, before being rescued. The findings included: On , the Administrator provided the Elopement Risk Policy, exhibit 10, no revision or effective date. Policy indicated, "It is the purpose and policy of the Community to provide a safe and secure living environment for all residents." This policy also includes safety measures to be in place for those residents who may be at risk for elopement. The last bulletin point in the policy reads, "Executive Director, or the designee, will follow up with the authorities, family/responsible party and the state as required." A copy of the run sheet was obtained for for Resident #12 which documented the following: was soaking wet, took sweater off and wrapped her in blankets. walked away from her ALF and jumped in a canal. Witness on scene saw the incident and advised the patient did not go under water. They immediately got her out. offers no complaining other than being and wanting dry clothes. VS assessed. assessment completed. Returned patient to ALF. Staff made aware of incident, and they agree she	A 025		

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A 025	Continued From page 3 does not need to be sent to the ER for evaluation. Record review of Resident #12's chart revealed an 1823 Health Assessment form (1823) dated . . . . . 1823 indicated resident had diagnosis to include , , and and was identified as an elopement risk. Further review of Resident 12's chart revealed no documentation of any occurrence on . . . . . , no progress notes for , no documentation of condition on return by . . . , no documentation of family or physician being notified of incident. Nothing at all was found in the chart indicating this incident had occurred. A review of facility incident reports for . . . revealed no incident report for this incident on . . . . . . Interview on . . . . . at 10 a.m., Surveyor asked Resident #12 if she had a problem involving water a short time ago. Resident #12 seemed to immediately remember and said "Oh Yes, I prayed to God not to take me and he didn't. I thought it was only (used to show approximately 5 inches) but it wasn't, I went right in." Resident #12 said it didn't happen there at the facility but away from there. She was unable to offer much more for details. Interview on at 11:23 a.m., the Administrator said on . . . . . Resident #12 was observed to exit the gate of the memory care courtyard by a staff member and was later returned to the facility by Emergency Medical Services (. .) after someone in the neighborhood found Resident #12 and called 911. Administrator said at that time of the incident, there was only 1 staff member in the memory care unit and they were unable to follow Resident #12 as they had to monitor the other memory	A 025		

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A 025	Continued From page 4 care residents. Interview on at 3 p.m., medication tech Staff B said she was working in Assisted Living on . She said Resident #12 was noted to be missing from the memory care unit. She said they began a check and when they began to search outside, was pulling up with Resident #12 and they were told she was found in a canal with no injuries. Staff B said Resident #12 was wet, , and shivering. Staff B said the Administrator was in building at the time of the incident and had been getting in her car to check for the resident when pulled up. Staff B said it would be the Administrator who would have notified the family. Staff B said she thought the canal was a few roads down. Staff B said Resident #12 was not alert, she thought it was a whole different year, thought it was a different president, and said she was walking home from work. Staff B said she did not see Resident #12 leave the building, but believed she went out the gate behind memory care and said the gate would release after 15 seconds and allow anyone out. Staff B said she thought someone saw the gate was open and realized Resident #12 wasn't there. Staff B said the gate beeps, kind of a quiet beep not really loud. Interview on at 9:32 a.m., medication tech Staff D said on she was working the memory care unit with resident aide Staff E. Staff D said she had left the unit to pass meds in the Assisted Living leaving Staff E on the unit alone. Staff D said she was off the unit approximately 30 minutes and when she returned, she discovered Resident #12 was missing. She said she performed a count and she and Staff E went through every room in memory care. Staff D said she checked the courtyard and discovered the	A 025		

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A 025	Continued From page 5 gate was open but not alarming. Staff D said she did not see Resident #12 go outside. Staff D said the Administrator was onsite at the time and notified. She said the Administrator had got in her car to check the surrounding area for Resident #12. Staff D said when she went outside to check the grounds, an . van pulled up and asked if we were looking for Resident #12. Resident #12 had nothing on her identifying who she is or where she lived, but the had been to the building multiple times in the past so assumed Resident # have lived there. told Staff D that they had Resident #12 in the of the bus, that she had in the canal, a nearby homeowner saw her and pulled her out. Staff D said Resident #12 was soaking wet to and said she wanted to go swimming and was looking for her husband. Staff D said she contacted the Administrator who was off in her car looking for Resident #12 and advised her had returned Resident #12 to the building. Staff D said she filled out an incident report and placed it in the Director of Nursing (DON) mailbox. Interview on at 10:48 a.m., resident aide Staff E said he was working the memory care unit on along with medication tech Staff D. Staff E said Staff D had left the unit to pass medications in the Assisted Living and when she returned to the unit, Staff D discovered Resident #12 was missing. Staff E said he had not known Resident #12 was missing and did not see her exit the unit. Staff E explained the power had gone out the day before and they hadn't reset the alarm on the gate. He said Resident #12 was one of those who tries to leave and she must have gone out the gate. He said they began an elopement search and then that was when brought her to the building. Staff E said he	A 025		

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A 025	Continued From page 6 did not speak with . . Staff E said Resident #12 was soaking wet and they gave her a whole shower and cleaned her up. He said Resident #12 did not have any identifying info on her. A review of facility adverse incidents reported to the Agency revealed no adverse incident report had been filed with the Agency for this incident. On at 11:23 p.m., Administrator admitted she had been in the building at the time of the incident with Resident #12 and was aware of it. She said it had been reported to her that resident was observed exiting the gate by one of the team members in the Memory Care area but they could not go after the resident as they were the only staff in the memory care unit and they could not leave the other residents alone. Administrator could not recall which team member this was. Administrator said a search ensued and the Administrator herself was getting into her car to search the surrounding neighborhood. Administrator said she was notified that returned the resident to the facility and she heard that Resident #12 was thinking of being in the canal, but, was not aware of her actually being in the canal. Administrator admitted there was no documentation to be found of the incident in the chart or any filed report. The Administrator said the day following the incident she was taken out for an illness and the Vice President (VP) took over the building. Administrator said between the VP and her, they missed the documentation and reporting. Administrator admits she cannot verify when Resident #12 exited the building, how long Resident #12 was out of the building in the community on her own, what condition she was in when returned to facility by , nor that the family or physician had been notified.	A 025		

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A 025	Continued From page 7 Administrator said the door in the [redacted] was checked and they discovered there had been a power outage for a short time due to a storm and the power lock had possibly lost power, so it was reset. Administrator said they had not considered it an elopement because they thought staff saw her exit. Administrator admits even if this was so, the moment Resident #12 would have turned the corner, no one had [redacted] on her or knew Resident #12's whereabouts. Class 1 .	A 025		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the	A 030		

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A 030	Continued From page 8 Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the	A 030		

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A 030	Continued From page 9 resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from	A 030		

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A 030	Continued From page 10 community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . . . . for health care services, the provision of or arrangement of transportation to health care . . . . . , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated	A 030		

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A 030	Continued From page 11 mentally , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State	A 030		

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A 030	Continued From page 12 Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review, and interviews, the facility failed to ensure residents received	A 030		

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(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 030	Continued From page 13 assistance with obtaining access to adequate and appropriate health care including the management of medications for 2 (Residents #1, and #9) of 3 residents reviewed for management of medications. The findings included: Facility policy titled Assistance with Self-Administration of Medication, effective [redacted] lists on page 2 under title of Missed or Refused Medications: 1. Missed or refused medications are documented on the MAR and the physician is notified. 2. Physician instructions regarding the missed dose are to be followed. 3. The Administrator will re-assess the resident and contact the physician and responsible part if the resident is continually refusing a medication(s). 1. Interview on [redacted] at 10:15 a.m., Resident #1 said he does not always get all of his medications. He said Saturday in the morning he is to get 8 pills, that morning he got 4. He said some nights its 1 pill, sometimes 2, sometimes 3. He said he spoke to the lady at the front desk who told the Director of Nursing (DON) said they will take care of it, but they do nothing. Review of Resident #1's Medication Observation Record for month of [redacted], and [redacted] revealed he did not receive an [redacted] medication on [redacted] and [redacted] and documented as medication not on cart at this time, awaiting pharmacy to deliver. MOR also revealed he refused an [redacted] on [redacted], had refused a sleep aid on [redacted], 21 & 22 and that the sleep aid was not available on the cart from [redacted]. MOR also showed resident refused multiple medications from [redacted].	A 030		

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	AL11911654	A. BUILDING: _____ B. WING _____	10/13/2021

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A 030	Continued From page 14 Record review of Resident #1's chart revealed a progress note dated that read, "Resident refusing medications. Stating he does not need what we are giving him. When I spoke to the resident he claims they did not give him his medications. Staff stating resident is refusing when medication was brought to him. NP [Nurse Practitioner] aware. NP here and spoke to resident about refusing his medications." 2. On at 10:30 a.m., Resident #9 said she wears a , patch on her . She says there are days she doesn't get it put on her and she doesn't know why. She said she does not take it off her . Review of Resident #9's MOR for month of indicates she is ordered 5% patch, (patch) to affected area in the morning, leave on for 12 hours, then remove at nighttime daily. On at 7 p.m., indicates patch was not in the med cart. On a.m., patch was marked as having been given, but at 7 p.m. that evening staff documented patch was not on resident. On at 6 a.m., morning staff marked patch not in the med cart at that time, however night shift documented they removed at night. On , 6, 7, and 8 morning, the patch was documented as having been placed on resident, however on , 6, and 8 it was documented the patch was not on the resident. The evening staff member was medication tech Staff B. Interview on at 10:20 a.m., medication tech Staff F said she documented the patches as not on the cart and not given at 6:00 a.m. on . She said they were on the cart currently	A 030		

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A 030	Continued From page 15 but does not know when they came in. Interview on [redacted] at 3:56 p.m., medication tech Staff B said she found Resident #9 to be without a patch 4 or 5 times in the past week. She said on [redacted] at 7:00 p.m. she documented the patches were not in the cart. Staff B said she made the DON aware of the patch not being placed on Resident 9's [redacted], but did not know if anything was followed up on. Review of Resident #9's chart revealed no documentation the health care practitioner had been notified of the missed doses. Interview on [redacted] at 11:32 a.m., the Nurse Practitioner (NP) said she has been coming to the facility twice a week for the past month. NP said she should be notified if residents are missing doses of medications. She said she had not been made aware that Resident #9 had not received her [redacted] patch on several occasions. NP said the missing doses and refused meds with Resident #1 were of concern. She said she had been made aware that he refused 1 medication once, but was not aware of the volume of refusals in [redacted]. NP said a few of the medications that Resident #1 had been refusing were not the type of medication that were safe to just stop. They were medications that needed to be tapered off over time. NP said had she been made aware of this, she certainly would have addressed it. NP said she would speak with the DON to put in a process in place to alert her of missed doses or refused medications. Interview on [redacted] at 3:10 p.m., the DON said they currently had no process right now if a resident refused or missed medications. DON	A 030		

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A 030	Continued From page 16 said she usually documents it in the chart if it was missed for a few days but there was currently no process/policy for contacting NP to inform her of this. Class III .	A 030		
A 032 SS=J	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained 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.	A 032		

Agency for Health Care Administration

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A 032	Continued From page 17 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review, observations, and interviews, the facility failed to provide adequate supervision for 1 (Resident #12) of 1 elopement reviewed. Failed to insure residents identified as elopement risks had identification on them for 8 (Resident #11, #12, #20, #21, #22,#23, #24, and	A 032		

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A	Continued From page 18 #25) of 8 elopement reviewed. Failure to provide adequate supervision allowed the resident with . . . . . to elope from the secured unit, and ended up in a canal, before being rescued. The findings included: On , the Administrator provided the Elopement Risk Policy, exhibit 10, and Elopement and Missing Resident Plan, no revision or effective date for either policy. The Elopement Risk Policy, exhibit 10 indicated, "It is the purpose and policy of the Community to provide a safe and secure living environment for all residents." This policy also includes safety measures to be in place for those residents who may be at risk for elopement. The last bulletin point in the policy reads, "Executive Director, or the designee, will follow up with the authorities, family/responsible party and the state as required." Neither of the 2 policy and procedures included the needed, upon admission or at the time the resident is determined to be an elopement risk, procedure to take a photo of the resident and to place identification on the resident which included the resident's name, the facility name, address and telephone number, or for the staff to check for the identification at least daily or as needed to ensure identification was always in place for residents identified as an elopement risk. A copy of the run sheet was obtained for . . . . . for Resident #12 which documented the following: was soaking wet, took sweater off and wrapped her in blankets. walked away from her ALF and jumped in a canal. Witness on scene saw the incident and advised the patient did not go under water. They immediately got her out. offers no complaining other than being and wanting dry clothes. VS assessed.	A 032		

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A 032	Continued From page 19 assessment completed. Returned patient to ALF. Staff made aware of incident, and they agree she does not need to be sent to the ER for evaluation. Record review of Resident #12's chart revealed an 1823 Health Assessment form (1823) dated . . . . . 1823 indicated resident had diagnosis to include , , and and was identified as an elopement risk. Further review of Resident 12's chart revealed no documentation of any occurrence on . . . . . , no progress notes for , no documentation of condition on return by . . , no documentation of family or physician being notified of incident. Nothing at all was found in the chart indicating this incident had occurred. A review of facility incident reports for , . . revealed no incident report for this incident on . . . . . . A review of facility adverse incidents reported to the state revealed no adverse incident report had been filed with the State for this incident. Observation on at 10:00 a.m., during a tour of memory care unit with medication tech Staff A. of the 18 residents on the unit at that time, 12 residents were found to be without an identification . Residents lacking a included the 8 residents identified at elopement risks (Residents #11, 12, 20, 21, 22, 23, 24 and 25). Staff A said the residents are supposed to have a on their arm with name & facility name on it. Observation on . . . . at 12:13 p.m., the DON provided list of 8 memory care residents identified as elopement risk on the Health Assessment Form 1823. The DON said the family is asked about any previous /elopement on admission, but the HA Form 1823 is what they go	A 032		

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A 032	Continued From page 20 by. She said she personally had put the . . . . . on all of them, but they take them off or they get lost. The DON agreed that all 8 residents were not wearing a when memory care was toured by the DON and the surveyor at 11:15 a.m. Interview on . . . . . at 3 p.m., medication tech Staff B said she did not see Resident #12 leave the building on . . . . . , but believed she went out the gate behind memory care and said the gate would release after 15 seconds and allow anyone out. Staff B said she thought someone saw the gate was open and realized Resident #12 wasn't there. Staff B said the gate beeps, kind of a quiet beep not really loud. Observation on at 11:45 a.m., revealed the gate to the outdoors does have an alarm. it was noted to not be loud. The alarm was left running and could not be heard in the common area with people talking. The same was true of the alarms on the exit doors at the ends of the hallway. Interview on at 11:45 a.m., the administrator agreed it would be easy to miss an alarm. The Administrator said she was unsure if anyone had checked to see if the alarms could be heard throughout the unit. Interview on at 9:32 a.m., medication tech Staff D said on . . . . she was working the memory care unit with resident aide Staff E. Staff D said she had left the unit to pass meds in the Assisted Living leaving Staff E on the unit alone. Staff D said she was off the unit approximately 30 minutes and when she returned, she discovered Resident #12 was missing. She said she performed a count and she and Staff E went through every room in memory care. Staff D said she checked the courtyard and discovered the	A 032		

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A 032	Continued From page 21 gate was open but not alarming. Staff D said she did not see Resident #12 go outside. Staff D said the Administrator was onsite at the time and notified. She said the Administrator had got in her car to check the surrounding area for Resident #12. Staff D said when she went outside to check the grounds, an . van pulled up and asked if we were looking for Resident #12. Resident #12 had nothing on her identifying who she is or where she lived, but the had been to the building multiple times in the past so assumed Resident # have lived there. told Staff D that they had Resident #12 in the of the bus, that she had in the canal, a nearby homeowner saw her and pulled her out. Staff D said Resident #12 was soaking wet to and said she wanted to go swimming and was looking for her husband. Staff D said she contacted the Administrator who was off in her car looking for Resident #12 and advised her had returned Resident #12 to the building. Staff D said she filled out an incident report and placed it in the Director of Nursing (DON) mailbox. Interview on at 10:48 a.m., resident aide Staff E said he was working the memory care unit on along with medication tech Staff D. Staff E said Staff D had left the unit to pass medications in the Assisted Living and when she returned to the unit, Staff D discovered Resident #12 was missing. Staff E said he had not known Resident #12 was missing and did not see her exit the unit. Staff E explained the power had gone out the day before and they hadn't reset the alarm on the gate. He said Resident #12 was one of those who tries to leave and she must have gone out the gate. He said they began an elopement search and then that was when brought her to the building. Staff E said he	A 032		

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A 032	Continued From page 22 did not speak with . . Staff E said Resident #12 was soaking wet and they gave her a whole shower and cleaned her up. He said Resident #12 did not have any identifying info on her. On at 11:23 p.m., Administrator admitted she had been in the building at the time of the incident with Resident #12 and was aware of it. She said it had been reported to her that resident was observed exiting the gate by one of the team members in the Memory Care area but they could not go after the resident as they were the only staff in the memory care unit and they could not leave the other residents alone. Administrator could not recall which team member this was. Administrator said a search ensued and the Administrator herself was getting into her car to search the surrounding neighborhood. Administrator said she was notified that returned the resident to the facility and she heard that Resident #12 was thinking of being in the canal, but, was not aware of her actually being in the canal. The Administrator admitted she could not verify when Resident #12 exited the building, how long Resident #12 was out of the building in the community on her own, what condition she was in when returned to facility by , nor that the family or physician had been notified. Administrator said the door in the was checked and they discovered there had been a power outage for a short time due to a storm and the power lock had possibly lost power, so it was reset. Administrator said they had not considered it an elopement because they thought staff saw her exit. Administrator admits even if this was so, the moment Resident #12 would have turned the corner, no one had , on her or knew Resident #12's whereabouts.	A 032		

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A 032	Continued From page 23 Class 1 .	A 032		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , . , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist.	A 056		

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A 056	Continued From page 24 (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name,	A 056		

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A 056	Continued From page 25 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure that prescriptions for residents who receive assistance with self-administration of mediations are filled or refilled in a timely manner. The facility also failed to ensure any change in directions for use of a medication are promptly recorded in the Medication Observation Record and an alert label placed on the medication container that directs staff to examine the revised directions for 2 (Resident #1 and #9) of 3 residents reviewed for medication assistance. The findings included: Facility policy titled Assistance with Self-Administration of Medication, effective , lists on page 1 under title of Medication Refills: 1. The facility will contact the dispensing pharmacy to obtain a refill at least seven days prior to running out of the medications, unless the medication is on a cycle refill with the pharmacy. 2. If necessary, the prescribing physician will be contacted to obtain a new order. 1. Interview on at 10:15 a.m., Resident #1 said he does not always get all of his medications. He said Saturday in the morning he	A 056		

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(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 056	Continued From page 26 is to get 8 pills, that morning he got 4. He said some nights its 1 pill, sometimes it's 2, sometimes 3. He said he spoke the lady at the front desk who told the Director of Nursing (DON), said they will take care of it but they do nothing. Review of Resident #1's Medication Observation Records (MOR) through revealed: Resident #1 was ordered a patch to be applied each morning and removed at night. It was documented the patch was not available in the cart, awaiting pharmacy to deliver on: and Resident#1 was ordered an medication, this was documented as not available in the cart, awaiting pharmacy to deliver on: , and . Resident #1 was ordered an and was marked med not in cart at this time, awaiting pharmacy to deliver on and . Resident #1 was ordered a sleep aide medication and was marked med not in cart at this time, awaiting pharmacy to deliver on 2. Interview on at 10:30 a.m., Resident #9 said she wears a patch on her . She says there are days she doesn't get it put on her and she doesn't know why. Review of Resident #9's MOR through revealed: Resident #9 was ordered an medicine, this was marked med not in cart at this time on , and . Resident # 9 was ordered an medicine, this was marked med not in cart at this	A 056		

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	AL11911654	A. BUILDING: _____ B. WING _____	10/13/2021

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A 056	Continued From page 27 time, awaiting pharmacy to deliver on and . Resident #9 was ordered a , patch, this was marked med not in cart at this time on , and . 3. Interview on at 9:52 a.m., medication tech Staff G said when the medications gets low, about pills left, she checks to make sure it wasn't already reordered by a previous med tech. If it hasn't, she will notify the nurse and make an order to the pharmacy for more to come in. Staff G said it normally takes days for a med to come in. Interview on at 3:56 p.m., medication tech Staff B said if a medication is running out, she will notify the Director of Nursing (DON), then reorder. Staff B said normally the DON can call the pharmacy and make it stat (emergency). Staff B said they have pharmacy sheets to fill out and fax over to the pharmacy. Staff B said it happens frequently that things aren't available or haven't been delivered. Interview on at 9:20 a.m., the DON said the process is the pharmacy comes in on the 3rd of the month and fills all the meds for the entire month. DON explained if there is a change during the month they will send a new pack with a new label. DON said Resident #1 probably didn't receive his sleep aide from /21 because there had been an increase from 5 milligrams (mg) to 10 micrograms (mgs) and they didn't have the new med from pharmacy. DON did not seem aware an alert label could have been placed on the 5 mg. tablets and refer to the new orders. DON said she had been aware of Resident #1 saying he didn't get his meds but when she talked to staff, they told her he had	A 056		

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A 056	Continued From page 28 been refusing. DON said she didn't really do any further investigation. Interview on at 10:35 a.m., the DON said if a medication gets low through the month, the process is supposed to be the med tech makes the request to pharmacy for the refills. DON said she is supposed to follow up and does the best she can, but she had done no follow up to see why there are missed doses. Class III .	A 056		
A 079 SS=J	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy	A 079		

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A 079	Continued From page 29 beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or	A 079		

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A 079	Continued From page 30 manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents,	A 079		

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A 079	Continued From page 31 resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively.	A 079		

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A 079	Continued From page 32 This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to maintain adequate staffing levels in the memory care unit to provide resident supervision, and provide scheduled and unscheduled service needs for all residents in the memory care unit. Per Florida Administrative Code 59A-36.010 (3) (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. Failure to staff to ensure adequate supervision allowed the resident with . . . . . to elope from the secured unit, and ended up in a canal, before being rescued. The findings included: A copy of the . . . run sheet was obtained for . . . for Resident #12 which documented the following: " . . [patient] was soaking wet, took sweater off and wrapped her in blankets. . walked away from her ALF [assisted living facility] and jumped in a canal. Witness on scene saw the incident and advised the patient did not go under water. They immediately got her out. . offers no complaining other than being . . . and wanting dry clothes. VS [vital signs] assessed. . assessment completed. Returned patient to ALF. Staff made aware of incident, and they agree she does not need to be sent to the ER for evaluation."	A 079		

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A 079	Continued From page 33 Interview on at 11:23 a.m., the Administrator said on Resident #12 was observed to exit the gate of the memory care courtyard by a staff member and was later returned to the facility by Emergency Medical Services after someone in the neighborhood found Resident #12 and called 911. Administrator said at that time of the incident, there was only 1 staff member in the memory care unit, and they were unable to follow Resident #12 as they had to monitor the other memory care residents. The memory care unit consists of a common area in the center, that has doors that exit out to a courtyard with a gated fence. Two long (at least 50 long) hallways split off in either direction. At the end of each hallway, it splits in two directions with rooms off in both directions. A staff member helping a resident in a room, especially off the split section of the hallways would have no direct line of site to anyone in either the common areas or courtyard. Staff in the long hallway could only see the resident while in the long hallway and would be too far away to hear any alarm. Observation of the memory care unit throughout the survey from to revealed multiple residents (including Resident #12) continuously pace and forth in these hallways and to the common area. Observation on at 10:00 a.m., during a tour of memory care unit with medication tech Staff A, of the 18 residents on the unit at that time, 12 residents were found to be without an identification . Residents lacking a included the 8 residents identified at elopement	A 079		

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A 079	Continued From page 34 risks (Residents #11, 12, 20, 21, 22, 23, 24 and 25). Staff A said the residents are supposed to have a [redacted] on their arm with name & facility name on it. Observation on [redacted] at 12:13 p.m., the DON provided list of 8 memory care residents identified as elopement risk on the Health Assessment Form 1823. The DON said the family is asked about any previous [redacted] /elopement on admission, but the HA Form 1823 is what they go by. She said she personally had put the [redacted] on all of them, but they take them off or they get lost. The DON agreed that all 8 residents were not wearing a [redacted] when memory care was toured by the DON and the surveyor at 11:15 a.m. Interview on [redacted] at 9:32 a.m., Staff D (med tech) said on [redacted], she was working the memory care unit with Staff E (resident aide). Staff D said she was a med tech, and she left the unit at times through the shift to pass medications in Assisted Living which would leave Staff E on the unit alone. Staff D said she was off the unit approximately 30 minutes and when she returned to the memory care unit she discovered Resident #12 was missing. Staff D said she did not see Resident #12 leave but found the courtyard gate was open and not alarming. Interview on [redacted] at 10:48 a.m., resident aide Staff E said he was working the memory care unit on [redacted] along with Staff D (med tech). Staff E said when Staff D returned to the unit after passing medications in Assisted Living, Staff D discovered Resident #12 was missing. Staff E said he had not known she was missing and did not see Resident #12 exit the unit. Interview on [redacted] at 2 p.m., the Director of	A 079		

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A 079	Continued From page 35 Nursing (DON) said the memory care unit is staffed by 1 person who does all the personal care and a med tech. She says the memory care med tech will also float out to Assisted Living to pass medications. DON said the memory care is basically staffed with 1.5 people and agreed there would be times throughout the shift when there was only 1 staff member in the unit. She said there were currently 20 people in memory care unit. Interview on at 3:30 p.m., the Administrator agreed that when there is only one staff person on the memory care unit, it would be difficult to monitor the entire group in Memory care especially if the caregiver was busy in a resident room. Class I .	A 079		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 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 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 165		

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A 165	Continued From page 36 (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or 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 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.	A 165		

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A 165	Continued From page 37 (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. This Statute or Rule is not met as evidenced by: Based on record review, and interviews, the facility failed to provide within 1 business day after the occurrence of an adverse incident a preliminary report to the Agency for Health Care	A 165		

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A 165	Continued From page 38 Administration (AHCA) and after investigation provide within 15 days, a full report to AHCA regarding an adverse incident including the results of the facility's investigation into the adverse incident for 1 (Resident #12) of 1 elopement reviewed. The findings included: A review of facility adverse incidents reported to the Agency revealed no adverse incident report had been filed with the Agency for this incident either Day 1 or Day 15 after a thorough investigation of Resident #12's elopement from the facility on . . . . . . A copy of the . . . run sheet was obtained for . . . for Resident #12 which documented the following, " [patient] was soaking wet, took sweater off and wrapped her in blankets. walked away from her ALF and jumped in a canal. Witness on scene saw the incident and advised the patient did not go under water. They immediately got her out. offers no complaining other than being . . . and wanting dry clothes. VS (vital signs)assessed. assessment completed. Returned patient to ALF. Staff made aware of incident, and they agree she does not need to be sent to the ER for evaluation." Record review of Resident #12's chart revealed an 1823 Health Assessment form (1823) dated . . . . . HA Form 1823 indicated the resident had diagnosis to include , and and was identified as an elopement risk. Further review of Resident 12's chart revealed no documentation of any occurrence on . . . . . , no progress notes for , no documentation of condition on return by . . . , no documentation of family or physician being notified of incident.	A 165		

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A 165	Continued From page 39 Nothing at all was found in the chart indicating this incident had occurred. Interview on at 3:00 p.m., medication tech Staff B said she was working in Assisted Living on on the 2:00 p.m. - 10:00 p.m. shift. She said during the shift Resident #12 was noted to be missing from the memory care unit. She said they began a check and when they began to search outside, Emergency Medical Services (. .) was pulling up with Resident #12 and they were told she was found in a canal with no injuries. Staff B said Resident #12 was not alert, she thought it was a whole different year, thought it was a different president, and said she was walking home from work. Staff B said she did not see Resident #12 leave the building, but believed she went out the gate behind memory care and said it will release after 15 seconds and allow anyone out. Staff B said the gate beeps, kind of a quiet beep, but not really loud, but she wasn't in the memory care so can't really make any assumptions if it sounded or not. Interview on . . . . at 9:32 a.m., medication tech Staff D said on she was working the memory care unit with Staff E (Resident Aide). Staff D said she had left the unit to pass meds in the Assisted Living leaving Staff E on the unit alone. Staff D said she was off the unit approximately 30 minutes and when she returned, she discovered Resident #12 was missing. She said she performed a . . . . count and she and Staff E went through every room in memory care. Staff D said she checked the courtyard and discovered the gate was open but not alarming. Staff D said she did not see Resident #12 go outside. Staff D said the Administrator was onsite at the time and aware that Resident #12 was missing. She said the	A 165		

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	AL11911654	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OPAL AT CAPE CORAL	4920 VICEROY COURT CAPE CORAL, FL 33904

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A 165	Continued From page 40 Administrator had got in her car to check the surrounding area for Resident #12. Staff D said when she went outside to check the grounds, an Emergency Medical Services ( ) van pulled up and asked if they were looking for Resident #12. Resident #12 had nothing on her identifying who she is or where she lived, but the had been to the building in the past multiple times so assumed Resident # , have lived there. told Staff D that they had Resident #12 in the of the bus, that she had in the canal, a nearby homeowner saw her and pulled her out. Staff D said Resident #12 was soaking wet to and said she wanted to go swimming and was looking for her husband. Staff D said she contacted the Administrator who was off in her car looking for Resident #12 and advised her had returned Resident #12 to the building. Staff D said she filled out an incident report and placed it in the Director of Nursing (DON) mailbox. Interview on at 10:48 a.m., Staff E (resident aide) said he was working the memory care unit on along with Staff D (med tech). Staff E said Staff D had left the unit to pass medications in the Assisted Living and when she returned to the unit, Staff D discovered Resident #12 was missing. Staff E said he had not known Resident #12 was missing and did not see her exit the unit. Staff E explained the power had gone out the day before and they hadn't reset the alarm on the gate. He said Resident #12 was one of those who tries to leave and she must have gone out the gate. He said they began an elopement search and then that was when brought her to the building. Staff E said he did not speak with . Staff E said Resident #12 was soaking wet and they gave her a whole shower and cleaned her up. He said Resident	A 165		

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A	Continued From page 41 #12 did not have any identifying info on her. Interview on . . . . at 11:23 p.m., Administrator admitted she had been in the building at the time of the incident with Resident #12 and was aware of it. Administrator said she had gotten in her car to search the surrounding neighborhood for Resident #12. Administrator admitted there was no documentation to be found of the incident in the chart or filed reports. The Administrator said the day following the incident she was taken out for an illness and the Vice President (VP) took over the building. Administrator said between the VP and her, they missed the documentation. The administrator verified she had not completed an investigation into how the resident got out of the building, if the alarms were working or not, or if staff on the unit could hear the alarms in order to respond to an elopement. Administrator verified an adverse incident report had not been filed with the Agency. The Administrator said she files the adverse incidents with the State and an elopement is an incident that should be filed. Administrator said they had not considered the incident with Resident #12 an elopement because they thought staff saw her exit. Administrator admitted even if this was so, the moment Resident #12 would have turned the corner, no one had _, . . on her or knew Resident #12's whereabouts. Administrator said other than resetting the alarm on the gate, no further investigation, retraining, elopement drills or corrective action had been put in place following the incident with Resident #12. Class III .	A 165		

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A 167	Continued From page 42	A 167		
A 167 SS=D	59A-36.018 FAC; 429.24 FS Resident Contracts 59A-36.018 Resident Contracts. (1) Pursuant to section 429.24, F.S., the facility must offer a contract for execution by the resident or the resident's legal representative before or at the time of admission. The contract must contain the following provisions: (a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services that the resident elects to receive; (b) The daily, weekly, or monthly rate; (c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule that must be attached to the contract; (d) A provision stating that at least 30 days written notice will be given before any rate increase; (e) Any rights, duties, or [illegible] of residents, other than those specified in section 429.28, F.S.; (f) The purpose of any advance payments or deposit payments, and the refund policy for such advance or deposit payments; (g) A refund policy that must conform to section 429.24(3), F.S.; (h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or [illegible] facility. The resident or responsible party must notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition	A 167		

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A 167	Continued From page 43 prevents the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible party to act on the resident's behalf; (i) A provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility; (j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those that the facility is licensed to provide, the resident or the resident's representative, or agency acting on the resident's behalf, must be notified in writing that the resident must make arrangements for transfer to a care setting that is able to provide services needed by the resident. In the event the resident has no one to represent him or her, the facility must refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions outlined in section 429.26(8), F.S., will take effect; (k) A provision that residents must be assessed upon admission pursuant to subsection 59A-36.006(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4), of that rule; (l) The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to rule 59A-36.008, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule; and, (m) The facility's policies and procedures related to a properly executed DH Form 1896, ... (2) The resident, or the resident's representative,	A 167		

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A 167	Continued From page 44	A 167		

must be provided with a copy of the executed contract.
(3) The facility may not levy an additional charge for any supplies, services, or accommodations that the facility has agreed by contract to provide as part of the standard daily, weekly, or monthly rate. The resident or resident's representative must be furnished in advance with an itemized written statement setting forth additional charges for any services, supplies, or accommodations available to residents not covered under the contract. An addendum must be added to the resident contract to reflect the additional services, supplies, or accommodations not provided under the original agreement. Such addendum must be dated and signed by the facility and the resident or resident's legal representative and a copy given to the resident or resident's representative.

429.24 FS
(1) The presence of each resident in a facility shall be covered by a contract, executed at the time of admission or prior thereto, between the licensee and the resident or his or her designee or legal representative. Each party to the contract shall be provided with a duplicate original thereof, and the licensee shall keep on file in the facility all such contracts. The licensee may not destroy or otherwise dispose of any such contract until 5 years after its expiration.

(2) Each contract must contain express provisions specifically setting forth the services and accommodations to be provided by the facility; the rates or charges; provision for at least 30 days' written notice of a rate increase; the rights, duties, and [illegible] of the residents, other than those specified in s. 429.28; and other matters that the parties deem appropriate. A new

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A 167	Continued From page 45 service or accommodation added to, or implemented in, a resident's contract for which the resident was not previously charged does not require a 30-day written notice of a rate increase. Whenever money is deposited or advanced by a resident in a contract as security for performance of the contract agreement or as advance rent for other than the next immediate rental period: (a) Such funds shall be deposited in a banking institution in this state that is located, if possible, in the same community in which the facility is located; shall be kept separate from the funds and property of the facility; may not be represented as part of the assets of the facility on financial statements; and shall be used, or otherwise expended, only for the account of the resident. (b) The licensee shall, within 30 days of receipt of advance rent or a security deposit, notify the resident or residents in writing of the manner in which the licensee is holding the advance rent or security deposit and state the name and address of the depository where the moneys are being held. The licensee shall notify residents of the facility's policy on advance deposits. (3)(a) The contract shall include a refund policy to be implemented at the time of a resident's transfer, discharge, or [illegible] (b) If a licensee agrees to reserve a bed for a resident who is admitted to a medical facility, including, but not limited to, a nursing home, health care facility, or [illegible] facility, the resident or his or her responsible party shall notify the licensee of any change in status that would prevent the resident from returning to the facility. Until such notice is received, the agreed-upon daily rate may be charged by the licensee. (c) The purpose of any advance payment and a	A 167		

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A 167	Continued From page 46 refund policy for such payment, including any advance payment for housing, meals, or personal services, shall be covered in the contract. (4) The contract shall state whether or not the facility is affiliated with any religious organization and, if so, which organization and its general responsibility to the facility. (5) Neither the contract nor any provision thereof relieves any licensee of any requirement or imposed upon it by this part or rules adopted under this part. (6) In lieu of the provisions of this section, facilities certified under chapter 651 shall comply with the requirements of s. 651.055. (7) Notwithstanding the provisions of this section, facilities which consist of 60 or more apartments may require refund policies and termination notices in accordance with the provisions of part II of chapter 83, provided that the lease is terminated automatically without financial penalty in the event of a resident's or relocation due to hospitalization or to medical reasons which necessitate services or care beyond which the facility is licensed to provide. The date of termination in such instances shall be the date the unit is fully vacated. A lease may be substituted for the contract if it meets the disclosure requirements of this section. For the purpose of this section, the term "apartment" means a room or set of rooms with a kitchen or kitchenette and lavatory located within one or more buildings containing other similar or like residential units. This Statute or Rule is not met as evidenced by:	A 167		

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A 167	Continued From page 47 Based on record review, and interview, the facility failed to provide services to residents in accordance resident contracts and resident service agreements and failed to employ sufficient and qualified staff to meet the needs of residents requiring these types of services for 5 (Residents # 16, #17, #7, #18, and #19 of 5 resident reviewed receiving home health services for medication assistance. The findings included: Record review of facility contracts for Residents #16, #17, #7, #18, and #19 indicated on pages residents are charged for services based on an assessment of level of personal assistance and care services based on the individuals' needs. Medication Levels are broken down into 2 levels, with charges based on number of medications a resident needs assistance with. Level 1 is for residents who need assistance with 8 medications or less. Level 2 is for residents needing assistance with 9 or more medications, including , medications, such as . Contract further states The Residence also provides Limited Nursing Services (LNS) services to those individuals requiring this service, and those individuals receiving Limited Nursing Services will be assessed utilizing the same assessment tool. Record Review of Resident #16's service agreement dated indicated he paid $475. Per month for Medication Level 2 services. Record Review of Resident #17's service agreement dated indicated she paid $475. Per month for Medication Level 2 services. Record review of Resident # 7's service agreement dated indicated she paid $475. per month for Medication Level 2 services.	A 167		

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A 167	Continued From page 48 Record Review of Resident # 18's service agreement dated indicated her type of insurance payment included all services offered by facility. Record Review of Resident # 19's service agreement dated indicated her type of insurance payment included all services offered by facility. Interview on at 9 a.m., the Director of Nursing (DON) said they have no residents receiving Limited Nursing Services. She said anyone requiring those type of services is referred to home health agencies to provide the services. DON provided a list of 29 resident receiving home health services. Residents #16, #17, # 7, #18, and #19 were noted to be receiving home health skilled nursing services for (medication used to manage levels). Interview on at 1:39 p.m., Resident #16 said he and his wife (Resident #17) said nursing came three times a day to monitor their and give them when needed. Interview on at 4:19 p.m., Resident #7 said she had been at the facility for 2 or 3 years. Resident #7 said the HHA had been doing her the whole time she lived there and they come 3 times a day. She said she was not sure if she was ever told the facility has a license that could provide that service. Interview on at 1:35 p.m., Resident #19 said the HHA comes in three times a day to do her , test her sugar level and give her an shot if needed. Resident #19 said she did not know the facility had a specialty license and could offer her these services. She said she probably would have let the staff do it had she	A 167		

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A 167	Continued From page 49 known they could. Interview on . . . at 1:35 p.m., the Administrator said it is not stated in the contract that . . . is a . . , . medicine, but yes, it would be considered a . , . medication. Administrator agreed this was a service that would be included under a LNS license. Administrator agreed that Residents #16, #17, #7, #18, and #19's assessment tool indicated they required Medication Level II services which included . , . medications. The Administrator said the facility doesn't place anyone on LNS services and does not give . because they do not have a nurse on staff 24 hours a day nor is there a Registered Nurse on staff or under contract to supervise the LNS and make monthly assessments. She said the facility refers those nursing services out to Home Health Agencies. Administrator said it was a corporate decision to maintain the LNS license. Class III	A 167		
AN277 SS=D	59A-36.022(2) FAC LNS - Resident Care Standards (2) RESIDENT CARE STANDARDS. (a) A resident receiving limited nursing services in a facility holding only a standard and limited nursing services license must meet the admission and continued residency criteria specified in Rule 59A-36.006, F.A.C. (b) In accordance with Rule 59A-36.010, F.A.C., the facility must employ sufficient and qualified staff to meet the needs of residents requiring limited nursing services based on the number of such residents and the type of nursing service to be provided.	AN277		

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AN277	Continued From page 50 (c) Limited nursing services may only be provided as authorized by a health care practitioner's order, a copy of which must be maintained in the resident's file. (d) Facilities licensed to provide limited nursing services must employ or contract with a nurse(s) who must be available to provide such services as needed by residents. The facility's employed or [redacted] nurse must coordinate with third party nursing services providers to ensure resident care is provided in a safe and consistent manner. The facility must maintain documentation of the qualifications of nurses providing limited nursing services in the facility's personnel files. (e) The facility must ensure that nursing services are conducted and supervised in accordance with Chapter 464, F.S., and the prevailing standard of practice in the nursing community. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to provide limited nursing services (LNS) to residents in accordance with facility license, resident contracts and resident service agreements and failed to employ sufficient and qualified staff to meet the needs of residents requiring these types of nursing services for 5 (Residents # 16, #17, #7, #18, and #19 of 5 resident reviewed receiving home health services for medication assistance. The findings included: Record review of facility contracts for Residents #16, #17, #7, #18, and #19 indicated on pages [redacted] residents are charged for services based on an assessment of level of personal assistance and care services based on the individuals' needs. Medication Levels are broken down into 2	AN277		

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AN277	Continued From page 51 levels, with [redacted] charges based on number of medications a resident needs assistance with. Level 1 is for residents who need assistance with 8 medications or less. Level 2 is for residents needing assistance with 9 or more medications, including [redacted] medications, such as [redacted]. Contract further states The Residence also provides Limited Nursing Services (LNS) services to those individuals requiring this service, and those individuals receiving Limited Nursing Services will be assessed utilizing the same assessment tool. Interview on [redacted] at 9 a.m., the Director of Nursing (DON) said they have no residents receiving Limited Nursing Services. She said anyone requiring those type of services is referred to home health agencies to provide the services. DON provided a list of 29 resident receiving home health services. Residents #16, #17, # 7, #18, and #19 were noted to be receiving home health skilled nursing services for (medication used to manage [redacted] levels). Record Review of Resident #16's service agreement dated [redacted] indicated he paid $475. Per month for Medication Level 2 services. Record Review of Resident #17's service agreement dated [redacted] indicated she paid $475. Per month for Medication Level 2 services. Record review of Resident # 7's service agreement dated [redacted] indicated she paid $475. per month for Medication Level 2 services. Record Review of Resident # 18's service agreement dated [redacted] indicated her type of insurance payment included all services offered by facility. Record Review of Resident # 19's service agreement dated [redacted] indicated her type of insurance payment included all services offered	AN277		

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THE OPAL AT CAPE CORAL	4920 VICEROY COURT CAPE CORAL, FL 33904

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AN277	Continued From page 52 by facility. Interview on at 1:39 p.m., Resident #16 said he and his wife (Resident #17) said nursing came three times a day to monitor their and give them when needed. Interview on at 4:19 p.m., Resident #7 said she had been at the facility for 2 or 3 years. Resident #7 said the HHA had been doing her the whole time she lived there and they come 3 times a day. She said she was not sure if she was ever told the facility has a license that could provide that service. Interview on at 1:35 p.m., Resident #19 said the HHA comes in three times a day to do her , test her sugar level and give her an shot if needed. Resident #19 said she did not know the facility had a specialty license and could offer her these services. She said she probably would have let the staff do it had she known they could. Interview on at 1:35 p.m., the Administrator said it is not stated in the contract that is a , medicine, but yes, it would be considered a , medication. Administrator agreed this was a service that would be included under a LNS license. Administrator agreed that Residents #16, #17, #7, #18, and #19's assessment tool indicated they required Medication Level II services which included , medications. The Administrator said the facility doesn't place anyone on LNS services and does not give because they do not have a nurse on staff 24 hours a day nor is there a Registered Nurse on staff or under contract to supervise the LNS and make monthly assessments. She said the facility refers those	AN277		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911654	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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AN277	Continued From page 53 nursing services out to Home Health Agencies, even when the service is already paid for by the resident. Administrator said it was a corporate decision to maintain the LNS license. Class III .	AN277		