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
	AL11969460	A. BUILDING: _____ B. WING _____	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BLAKE AT PENSACOLA OPERATING COMPANY	428 AIRPORT BLVD PENSACOLA, FL 32503

(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 A complaint investigation (complaint numbers 2020016334, 20200016702, 2021002137, 2021008190 and 2021011003) was conducted at The Blake At Pensacola Operating Company, LLC on on to . The facility had deficiencies at the time of the survey.	A 000		
A 032 SS=G	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. 2. The facility must have a photo identification of	A 032		

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A 032	Continued From page 1 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 observation, staff interview, family interview and record review, the facility failed to prevent a resident with a history of elopement from exiting the building unsupervised for 1 of 1 residents sampled with multiple elopements (Resident #4) and failed to ensure all direct care staff participated in elopement drills for 2 of 2	A 032		

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A 032	Continued From page 2 elopement drills conducted. Resident #4 eloped from the building via her bedroom window on [redacted] and [redacted]. The findings include: Resident #4 A review of the facility document, "Resident Incident History" dated [redacted] revealed that Resident #4's daughter called the facility on [redacted] at 11:57 AM, stating she received several phone calls from Resident #4 from an unknown telephone number. Further review of the document revealed a follow-up telephone call from Resident #4's daughter at 12:05 PM, notifying the nurse that Resident #4 was at a gas station near the facility. The document revealed Resident #4 was returned to the facility by the police. The facility initiated the missing resident protocol. A review of a second "Resident Incident History" form also dated [redacted] revealed the resident removed the security bar from the window in her room and walked to the gas station near the facility. The document revealed the window was repaired, Resident #4 was placed on frequent checks, and the facility conducted elopement drills and employee training. The form also indicated the daughter would visit more often so the resident would not attempt to leave to find the daughter. A review of a nurse's note dated [redacted], from the 7 AM to 3PM shift, revealed Resident #4 was observed climbing out of the window by Staff member B, the Walk with Me/Activities Director (WM/AD) who was driving past the facility. The note went on to reveal that Staff member B, WM/AD, pulled over and escorted the resident	A 032		

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A 032	Continued From page 3 ... to the memory care unit through the ... door. The note revealed Resident #4 stated, "I need to get out of here, I have too much stuff to do." The Agency for Health Care Administration, (AHCA) Recommended Form 1823, "Resident Health Assessment for Assisted Living Facilities," dated ... ... for Resident #4 was reviewed. The form indicated Resident #4 had generalized ... ..., forgetfulness and was dependent on others for her well being. Under the "Special Precautions", it was noted the resident was a ... risk; however, the elopement risk box was checked as, "No". On ... ... at approximately 10:45 AM, a telephone interview was conducted with the daughter of Resident #4, who stated she had received a telephone call from Resident #4, from a telephone number she did not recognize, she was unable to recall the date. The family member stated that Resident #4 told her she was at a home improvement store looking for her car. The family member recalled that she had received another telephone call a little later from Resident #4 that she was at a gas station. The family member stated she drove to the home improvement store and the gas station, located in the same shopping center, approximately 0.7 miles from the facility but the resident was not there when she arrived. She stated she received a telephone call from the facility notifying her that Resident #4 was at a gas station by the facility. The family member revealed that upon her arrival to the facility she found the resident to be ... ..., distraught, determined to find her car, and did not know "what was going on". The daughter revealed the resident was exhibiting ... ... behaviors at home, which was the	A 032		

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A 032	Continued From page 4 reason Resident #4 was admitted to the facility. The daughter stated that she, "didn't feel the management staff was reactive to the situation" after the resident's first elopement. On at approximately 2:30 PM, an interview was conducted with the Director of Wellness who revealed the facility completed elopement drills monthly on rotating shifts, so each shift had an elopement drill quarterly. The Wellness Director stated the facility did not report Resident #4's elopement on because the resident did not get all the way out the window and confirmed that Resident #4 would have left the facility if she had not been observed by Staff member B, WM/AD, and returned to the facility. The Wellness Director confirmed that after the first elopement on staff completed hourly safety checks for 72 hours and the window locks were repaired. She went on to confirm that after the second elopement the resident was moved to a room with a window that opened to an enclosed courtyard however no other precautions were put into place to prevent future elopements. On at approximately 2:59 PM, an interview was conducted with Staff A, Registered Nurse (RN), who revealed she was the nurse working when Resident #4 eloped on . . . . . and . She stated that Resident #4 was in a room which overlooked the parking lot, with a window that would slide up but was hard to open. Staff A confirmed the last time she recalled seeing Resident #4 on was at approximately 10:00 AM, when Resident #4 was participating in activities. Staff A, RN confirmed Resident #4 raised the window in her room and exited the facility. She further confirmed that Resident #4 was out of the window on . . . when Staff member B, WM/AD, found the	A 032		

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A 032	Continued From page 5 resident and escorted her . . . into the building. Staff A clarified the resident did not leave the property on .. .... because she got caught. On ..... at approximately 9:00 AM, an observation was made of the window in the room Resident #4 exited from. Observed in the window tracks was a white plastic strip on each side, extending the length of the window, minus approximately 3 inches. The surveyor found that the plastic strip was easily removed from the track (photographic evidence obtained). A review of the list of Memory Care Unit residents who are at risk for elopement was completed. Resident #4 was not included on the list. On at approximately 11:00 AM, an interview was conducted with Staff C, Assistant Wellness Director, who confirmed the list was a complete list of elopement risks on the Memory Care Unit, there was no explanation provided on why Resident #4 was not included on the list. On at approximately 3:23 PM, an interview was conducted with the Administrator who revealed residents were admitted to the Memory Care Unit for reasons such as elopement risk, , or other concern where the resident's safety is in question. An interview was conducted with the Wellness Director on at approximately 3:45 PM who stated when the facility received notification the resident was at the gas station on , she drove to the gas station to pick up the resident, but the resident was already in the police car. She stated the police transported the resident to the facility and stated she did not request a copy of the police report and did not get the deputy's name or badge number.	A 032		

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A 032	Continued From page 6 On at approximately 8:00 AM, an interview was conducted with Staff F, concierge, who stated the elopement book was located at the front desk and was currently up to date. A review of the book revealed approximately 100 residents with identifying information in the book. Staff F confirmed all current residents are listed in the book and she stated, "I just know who is an elopement risk". Staff F confirmed if another staff covered her shift, "they would probably not know who the elopement risks are". On at approximately 9:05 AM, an interview was completed with staff D, Personal Assistant, who confirmed she does not know which residents on the memory care unit are an elopement risk, and confirmed she primarily works on the Memory Care Unit. On at approximately 9:15 AM, an interview was conducted with staff G, Licensed Practical Nurse (LPN), who stated the Personal Assistants know who is at risk for elopement and confirmed there is a book which identifies the elopement risks. Staff G was unable to locate the elopement book and confirmed it was the first time she worked on the Memory Care Unit. On at approximately 9:24 AM, an interview was conducted with Staff F, Personal Assistant, who revealed the nurse and other personal assistants tell her who is at risk for elopement. Elopement Drills A review of the elopement drills provided by the facility was completed. An elopement drill was conducted on at 2:00 PM with 5 staff members noted to have participated. A second	A 032		

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A 032	Continued From page 7 drill was conducted on at 4:50 AM with 5 staff members noted to have participated. Review of the Background Screening roster revealed the facility has 46 direct care staff employed at the facility. An interview was conducted with the Wellness Director on at approximately 2:21 PM, who confirmed there were no other elopement drills conducted. On at approximately 9:05 AM, an interview was completed with staff D, Personal Assistant, who stated there have not been any elopement drills since she has worked at the facility. Her date of hire is noted to be . On at approximately 9:24 AM, an interview was conducted with Staff F, Personal Assistant, who stated she has not participated in an elopement drill since she has worked at the facility. Her date of hire is noted to be . A review of the resident admission packet was completed. On page 7 of the packet states, the memory care services provide specialized care for persons with 's , memory and who are at a risk for , elopement and/or are unable to direct their own activities of daily living. A review of the Policy/Procedure on elopement: Missing Resident-Elopement plan and Policy, last revised on was completed. Under Procedure, XI, the policy states: Complete an incident report and place the resident on Alert Status/All Shift Charting for 72 hours. Take steps to prevent a future elopement. Evaluate whether	A 032		

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A 032	Continued From page 8 the resident requires 24 hour one to one supervision, a sitting service, discharge for treatment and /or transfer to a secure environment in the Memory Care Community. Nursing staff are to ensure that employees reporting to the next shift are notified about the situation so that staff remain on alert and provide necessary supervision to the resident. Under elopement prevention strategies include: All windows are secured and cannot be opened more than 4" - this includes common area windows and windows in locked areas. Class II	A 032		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable ˘ to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes,	A 152		

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A 152	Continued From page 9 3. A dresser, ... or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to honor the resident's rights for a safe living environment by failing to ensure that chemicals, cleaning products and fire extinguishers were secured and not accessible to residents, which had the potential to impact all 36 residents residing in the Memory Care unit (MCU). The findings include: During the initial tour of the Memory Care Unit on . . . . . beginning at approximately 11:45 AM, an observation was made of a fire extinguisher by the double doors at the entrance of the memory care unit. The fire extinguisher case door was not closed, making the fire extinguisher accessible to the residents. Also during the tour, an observation was made of a door labeled housekeeping; the door was unlocked. An observation was made inside the housekeeping closet of a housekeeping cart with chemicals on	A 152		

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A 152	Continued From page 10 the cart, and multiple cleaning products on the shelves. (photographic evidence obtained) A review of the Admission Packet, page 7, section 2.4 under Memory Care Services revealed the community provides specialized care for persons with [redacted], Memory [redacted] and [redacted] who are at a risk for [redacted] elopement and/or are unable to direct their own activities of daily living. An interview was conducted on [redacted] at approximately 12:40 PM, with the Wellness Director who confirmed the housekeeping door should be locked when not in use. Class III	A 152		
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) An event over which facility personnel could exercise control rather than as a result of the	A 165		

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A 165	Continued From page 11 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. (7) The information reported to the agency pursuant to subsection (3) which relates to	A 165		

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A 165	Continued From page 12 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, policy review and interview, the facility failed to report an elopement for 1 of 2 residents sampled for elopement, (#4). The findings include:	A 165		

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A 165	Continued From page 13 A review of Resident #8 medical record was completed. A nurse note dated , 7 AM to 3 PM shift revealed resident #8 was "caught" climbing out of the window by Staff B, Activities Director as the employee was driving by the the facility. The note revealed the resident was escorted . . . to the memory care unit through the door. The note revealed Resident #8 stated, "I need to get out of here, I have too much stuff to do." An interview was conducted with the Wellness Director on . . . . . at approximately 2:30 PM. The Wellness Director revealed Resident #8 elopement on . . . . . was not reported as an elopement because the resident did not make it out of the window all the way. The Wellness Director stated that Staff B, had seen the resident climbing out the window and escorted the resident to the memory care unit. The Wellness Director confirmed the resident would have likely left the property if staff B had not driven past the facility. The Wellness Director confirmed Resident #8 eloped on , which was reported, and confirmed there was no incident report or investigation for the elopement on . . . . . She also verified that Staff B was no longer employed by the facility. An interview was conducted with Staff A, Registered Nurse, (RN), on . . . . . at approximately 2:59 PM. Staff A, RN, confirmed she was the nurse assigned to Resident #8 on . Staff A, RN confirmed Resident #8 was out of the window on . . . . . and stated Resident #8 would have left the property a second time if Staff B, Activities Director did not "catch" her. A review of the policy, "Missing Resident-Elopement Plan and , last	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969460	A. BUILDING: _____ B. WING _____	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 165	Continued From page 14 revised on . . . . . Under the section titled, Procedures, Under XI the policy stated: Complete an incident report and place the resident on Alert Status/All Shift Charting for 72 hours. Take steps to prevent a future elopement. Under Section XII the policy stated: Report elopement according to state regulations. Document any state notification on the company incident report. Class III	A 165		
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the . . . . . are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic . . . . submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address;	CZ814		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CZ814	Continued From page 15 . . ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview the assisted living facility failed to maintain employment status of all employees within the background screening clearinghouse for 1 of 6 sampled current staff records (Staff E). The findings include: On . . . . . at approximately 1:54 PM, the Director of Business Operations provided the surveyor with a copy of the background screening clearinghouse roster. A review was conducted of the background screening clearinghouse roster which failed to reveal staff E, a patient aide with a date of hire of . . . . . . On . . . . . at approximately 3:45 PM, an interview was conducted with the Director of Business Operations who confirmed these findings. Unclassified	CZ814		