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
	AL11911906	A. BUILDING: _____ B. WING _____	11/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DEER CREEK SARASOTA	8450 MCINTOSH ROAD SARASOTA, FL 34238

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint survey for #2021013424 was conducted on . . . . at Brookdale Deer Creek Sarasota, an assisted living facility in Sarasota, Florida. Complaint #2021013424 was substantiated with citation. The following is description of the deficiency. .	A 000		
A 032	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),	A 032		

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A 032	Continued From page 1 F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to 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, interview, and record review, the facility failed to ensure each resident identified as an elopement risk maintained and	A 032		

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A 032	Continued From page 2 checked for identifying information (resident name, name, address and phone number of the facility) on each resident daily for 10 (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10) of 10 residents who were identified by the facility as an elopement risk; Facility failed to ensure staff were aware of all residents at the facility who had a potential to elope and failed to ensure the policy included identification of resident and facility information and a process to ensure the information was present on each identified resident at least daily or as needed.. The findings included: Record Review of the Elopement Risk Policy - FL-4 effective and revised last in revealed the facility needed a photograph of at risk residents and elopement risk would be added to the service plan. The policy did not include the requirement for identification to be on the resident and checked at least each day by staff. The identification must include the residents name, name of facility, the address and telephone number of the facility. Interview on at 12:00 p.m., The Executive Director (ED) verified on Resident #1 had exited the building due to a staff member not ensuring one of the doors was secured. The ED said Resident #1 had been found near the door of the facility. Interview on at 9:58 a.m., Staff A stated she was not aware of any residents who were exit seeking or had issues with elopement. Interview on at 10:16 a.m., Staff B said there was probably one or two residents that would say they wanted to go home. She said all	A 032		

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A 032	Continued From page 3 the residents in the building were memory care residents. Staff B said she was not aware of any resident attempting to exit the building. Staff B said she was not aware of any resident getting outside of the building. Interview on . . . . at 10:30 a.m., Staff C said she was not aware of any resident getting outside of the building. Staff C identified Resident #3 as stating at times that she wanted to go home. Staff C said she had never observed resident #3 exit seeking. Staff C did not identify any other resident as an elopement risk. Interview on . . . . . at 10:30 a.m., the ED identified 10 residents who currently had exit seeking behaviors by placing a mark by the resident's name on the census. On at 12:25 p.m., Resident #2 was observed to not have any form of identification on her person with the name and address of the facility. At that time the acting Director of Nursing (DON) verified Resident #2 did not have any identification. The DON said none of the residents in the facility had identification on their person. Observations between 12:25 p.m. and 1:55 p.m. of the other nine residents identified as elopement risk verified they did not have any form of identification on their person. Record review revealed Residents #3, #5, #6, #7, #9 and #10 are identified on their 1823 as being a risk for elopement. Record review revealed Resident #1 is identified with ˛ behaviors on her service plan and on her Health Assessment Form 1823.	A 032		

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A 032	Continued From page 4 Record review revealed Resident #2 is not identified on the Health Assessment Form 1823 as an elopement risk. The Service plan did not list the resident has having ⌣ behaviors. Record review revealed Resident #4 was identified on her service plan as having ⌣ behaviors. She is not identified on her Health Assessment Form 1823 as a risk for elopement. Record review revealed Resident #8 is not identified on the Health Assessment Form 1823 or the Service Care plan as being an elopement risk. Interview on at 1:10 p.m., the ED said the facility did not currently have a system in place to ensure residents with a risk for elopement had identification with the name and address of the facility on their person daily. Class III	A 032		