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
	AL11969122	A. BUILDING: _____ B. WING _____	01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT DANIA BEACH	150 STIRLING RD DANIA BEACH, FL 33004

(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 (#2022000543) and Generator Monitoring survey was commenced on and concluded on at The Residence at Dania Beach. The facility had deficiencies identified related to the Complaint (#2022000543) at the time of the survey.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 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 025		

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A 025	Continued From page 1 (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to provide personal supervision and oversight to residents identified with [illegible] in the secured Memory Care Unit, while they were smoking to prevent potential for harm for 2 of 2 sampled residents, Resident #2 and Resident #3. The findings included: On at 10:00 AM, a tour of the Memory Care Unit was conducted. Resident #2 and Resident #3 were observed smoking on the south	A 025		

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A 025	Continued From page 2 east covered patio. The direct care staff was not present during observations on the following dates: . . . . . , ... and . . . . . . On . . . . . at 11:20 AM, an observation and interview was conducted with Resident #2. He was wearing shorts and was deeply tanned. He showed the seat compartment of his 4-wheel walker where he stored his cigarettes and lighter. During the interview he was unable to state the name of the facility, what room he resided in or how long he had lived here. On at 9:30 AM, an interview was conducted with Resident #3 in her room. She was asked if she had her lighter and cigarettes. She showed that her lighter was in her bag. She asked this surveyor if she had any cigarettes and asked if this Surveyor could get her some cigarettes from Staff A Memory Care Unit Resident Care Coordinator (RCC). Observation was made of a 2- floor , , tank in the room for the resident's roommate in her bed near the wall in addition to a table , , machine placed on the night stand next to the roommates bed. Further observation revealed there was a black ashtray on the nightstand partially covered by a pink piece of clothing. (Photographic evidence obtained.) On . . . . . at 1:00 PM, an interview was conducted with Resident #3 in the dining room. She stated she wanted to go home. When asked where did she live, she stated "I don't know." She was observed mumbling to herself, which appeared to be her behavior, based on several previous observations. Review of the Agency for Health Care Administration Resident Assessment (AHCA	A 025		

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A 025	Continued From page 3 1823 form) dated , revealed Resident #3 was admitted to the facility on with diagnoses to include , and bi-polar . The Resident Assessment further documented the resident had poor insight, she was oriented x 2, and disoriented to time. She was independent with ambulation, , eating, toileting and transferring. Review of a History and Physical dated , revealed Resident #3 requests cigarettes multiple times per day. Further, Resident #3 was admitted to Assisted Living due to increased agitation and . On at 9:40 AM, an interview was conducted with Resident #2. He was observed lying down in bed in his room. He was asked if he had his lighter and cigarettes. He was observed to pull his lighter from his shorts pocket and pulled his cigarettes out of the seat of the 4-wheel walker. On at 11:43 AM., Resident #2 was observed sitting outside on the south east smoker's patio. He was observed sitting outside alone. There were no ashtrays observed on the patio at this time. Review of the Resident Assessment AHCA 1823 form revealed Resident #2 was admitted to the facility on with diagnoses to include 's , left and unspecified On at 11:45 AM, Staff A RCC was shown the tanks in Resident #3's room.	A 025		

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A 025	Continued From page 4 Staff A RCC stated she did not know Resident #3 had a lighter. She further stated Resident #3's roommate was receiving hospice care services and the tanks were from the hospice agency. On at 2:10 PM, an interview was conducted with Resident #7 on the patio who stated Resident #3 is always begging for cigarettes and she has stolen his cigarettes in the past. He stated he gets tired of having to pick up the cigarette butts from the patio, because he stated she drops the butts on the patio when she finishes smoking. There were no ashtrays observed on or near the patio. There were 6 residents observed on the patio including Resident #2 and Resident #3. There were no staff members present providing supervision. Review of the Resident Supervision Policy dated states in part, 'The Residence at Dania Beach must provide care and services appropriate to the needs of residents accepted for admission to the facility. The Residence at Dania Beach must offer personal supervision as appropriate for each resident, including the following: Daily observation (maintaining daily observation log 2-hour check) on the residents that require additional assistance with bathing, ambulation and transfer 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. Maintain a general awareness of the resident's whereabouts.' On at 10:10 AM, an interview was conducted with the Administrator. She stated when the Memory Care Unit was opened a few years ago, the residents who lived in the general	A 025		

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A 025	Continued From page 5 ALF section, did not wish to move out of the Memory Care Unit, therefore, they are allowed to go out and smoke freely, but she also has Resident #2 and Resident #3 designated as Memory Care residents that smoke as well. She stated the staff look out the window to check on the residents when they are smoking. It was pointed out to the Administrator that the doors to the dining room were closed, locked and blocked by a Medication Cart as observed on and preventing a clear view. She confirmed she needed to add ashtrays to the patio area. She further stated she was not aware the residents maintained their smoking supplies on their person, stating the smoking supplies should be kept with the RCC at the nurse's station. On at 3:00 PM, interviews were conducted with direct care staff who work various shifts who confirmed they are not given assignments to check on the 2 Memory Care Unit smokers. The staff stated Resident #2 does smoke on the patio at night. Review of the facility Smoking Policy dated , revealed the facility has designated smoking areas, however does not address providing supervision to residents from the Memory Care Unit who smoke. On at 4:00 PM, an interview was conducted with the Administrator. She acknowledged the findings and concurred there was a potential for a risk of fire to all 32 residents residing on the Memory Care Unit. Class III	A 025		

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A 032	Continued From page 6	A 032		
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), 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	A 032		

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A 032	Continued From page 7 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 maintain a general awareness and whereabouts of residents to prevent elopement for those resident's identified as elopement risk who reside in the secured Memory Care Unit, for 1 of 1 sampled residents reviewed, Resident # 1. The findings included: Review of the facility's advertisement brochure documents in part, 'You're Invited! Are you looking for a safe, welcoming home with a friendly staff to look after your needs?'	A 032		

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A 032	Continued From page 8 On at 9:25 AM, an interview was conducted with the Administrator who stated on or , Resident #1 was scheduled to move into the community from the local hospital. She stated around 3:00 PM on , she called the local hospital and told the Discharge Planner they do not conduct facility admissions after 3:00 PM. The Discharge Planner told her Resident #1 was already dropped off at the facility about a half hour ago. She told them that it was impossible since she had checked the Memory Care Unit, and he was never dropped off in the Unit. The Administrator further stated the transportation company made a mistake and dropped Resident #1 off at the wrong side of the facility, dropping him off in the front of the building instead of the . She stated the facility did have a receptionist at the front desk, but residents are free to come and go, and Resident #1 walked out of the building. She stated she called the family and police and the staff started to look for him. Resident #1 was located by law enforcement on near his former apartment and he was returned to the Memory Care Unit. She stated Resident #1 was not her resident at this time, however she completed an adverse incident report. During the interview conducted on at 9:25 AM with the Administrator, she further stated on at around 4:00 PM, after Resident #1 finished eating in the dining room, caregiver Staff C alerted her that Resident #1 was missing from the Memory Care Unit. The Administrator stated she had determined Resident #1 had jumped over the chain link fence to exit the Memory Care Unit. The Administrator stated she did not have any surveillance cameras in that section of the building. She stated the staff	A 032		

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A 032	Continued From page 9 searched the facility and surrounding areas in the community and the resident was returned in approximately 40 minutes by local law enforcement who had inadvertently located the resident. She further stated she did not call law enforcement, or the resident's family, because the resident reappeared within a reasonable timeframe. She stated after this incident, they provided a 1 to 1 caregiver to watch him until he was discharged to a more secured Memory Care Unit located in another assisted living facility. She stated she had assessed Resident #1 when he was in the hospital and was not aware the resident was an elopement risk. A review of the google search on the website https://www.accuweather.com, revealed the temperature for between 4:00 PM and 5:00 PM, was 83 degrees Fahrenheit. A review of the facility Elopement Management policy dated states in part, 'Each caregiver is responsible for the whereabouts of the residents assigned to him/her. No reasonable period of time should pass when the caregiver is unaware of the resident's whereabouts. Every attempt will be made to locate a missing resident as quickly as possible. The caregiver will complete an incident report and incident investigation report to include as much information as possible: a. Clothing and footwear the resident was last seen wearing. b. Whether or not the resident had money or other personal belongings with him/her. c. Last time the resident was seen by the staff. d. Last meal eaten. e. Last medication administered. f. Mental status: , alert, oriented	A 032		

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A 032	Continued From page 10 . . . . , upset, angry, etc. Review of the Resident Supervision Policy dated states in part, 'The Residence at Dania Beach must provide care and services appropriate to the needs of residents accepted for admission to the facility. The Residence at Dania Beach must offer personal supervision as appropriate for each resident, including the following: Daily observation (maintaining daily observation log 2-hour check) on the residents that require additional assistance with bathing, ambulation and transfer 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. Maintain a general awareness of the resident's whereabouts.' On at 10:35 AM, an interview was conducted with Caregiver Staff D who stated she was present on the day Resident #1 was missing. She stated she saw transportation bring the resident into the facility through the front door in the general ALF (Assisted Living Facility). She stated she assumed transportation took him to the nurse's station. She stated she did not recognize the resident, and did not ask questions to the transportation driver, nor the resident. She stated on that date, she did see the resident go outside and sit for a while. She stated she never saw the resident again after that time. On at 11:20 AM, an interview was conducted with Medication Technician Assistant Supervisor Staff B who stated she works the 7:00 AM to 3:00 PM shift on the general ALF side. She stated she was on duty the day of the admission incident on . . . . . She stated the resident was brought to the general ALF side on a	A 032		

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A 032	Continued From page 11	A 032		

stretcher by the transportation driver who did not bring any paperwork with him and she failed to ask any questions about paperwork. She also stated she chatted with Resident #1, and he seemed alert so she sent him to lunch in the main dining room around 12:00 PM. She stated she saw him in the dining room but did not go to him and conduct the intake admission process. She stated she had been made aware of a new admission but not aware of his room number, nor that he was to go to Memory Care Unit. She stated she completed her shift at 3:00 PM and left the building. She stated she was not aware the resident had left the building until she came to work the following day.

Review of the Resident Health Assessment (AHCA 1823 form) dated for Resident #1, revealed Resident #1 was admitted to the facility on with diagnoses to include and . Resident #1 was alert and oriented x 1 and was independent with all his activities of daily living except bathing. He required daily reminders for important tasks and daily observations of his whereabouts and wellbeing. Resident #1 was documented an being an 'Elopement Risk.'

On at 10:00 AM, a tour of the Memory Care Unit was conducted with the Administrator. The unit is on the south east side of the Memory Care building where 32 residents reside in the secured Memory Care Unit. The Administrator entered a code into the keypad entry to gain access where she was met by the Resident Care Coordinator (RCC) and 2 direct care staff. The fire exit door, where Resident #1 allegedly eloped, was observed with a push bar to open the door and a latch located on the bottom of the fire door which was locked. The RCC unlatched the

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A 032	Continued From page 12	A 032		

door to allow exit to the outside. Upon going outside, a small incline ramp for wheelchairs was observed that led to the exit door. There was a metal guard-rail observed enclosing the inclined wheelchair ramp. The guard-rail was located approximately 1 away from the 6 chain link fence. There was another fire exit door located on the north west side of the Memory Care Unit next to an enclosed courtyard. The door was opened by pushing down on the bar on the door. The alarm sounded for approximately 3 seconds and could not be heard past 15 to 20 . . . away. There was an 8 . . . white wooden fence located on the perimeter of this courtyard.

On at 10:45 AM, an interview was conducted with Staff A RCC Supervisor of the Memory Care Unit. She stated staff on all shifts are not given a specific written resident assignment, but are responsible for taking care of all of the residents on the unit. She stated she was not made aware of the resident's first admission because the driver took him to the front of the building instead of bringing him to the Memory Care Unit. She stated when Resident #1 was returned to the facility, he came in very compliant with taking his medications and care. She stated they did not know Resident #1 had opened the door and jumped over the fence on , because as demonstrated, the alarm only sounds for a few seconds and the alarm does not sound loudly. She stated she was very shocked Resident #1 left the facility as he had never been exit seeking. She stated he was given a 1 to 1 caregiver after he returned the second time, and was discharged shortly thereafter.

On at 11:00 AM, an interview was conducted with Staff C Medication Technician on

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A 032	Continued From page 13 the Memory Care Unit who stated on , the day Resident #1 eloped, he had taken his morning medications and eaten his lunch. She stated they all take care of the residents and do not have a specific assignment. She went on to state the daytime housekeeper keeps an , on the residents as well. She stated on the date of the elopement from the Memory Care Unit, they searched the grounds of the facility, because they did not hear the alarm. She stated they could not find him and the police brought him . She stated Resident #1 was discharged from the facility soon after that. On at 3:00 PM, an interview was conducted with a local State Investigator who stated she had spoken to the law enforcement officer who returned Resident #1 to the facility. She stated law enforcement found the resident on a local freeway at the entrance to the local airport approximately 3 miles away from the facility. She stated the investigation concluded Resident #1 had been missing longer than 1 hour as identified by the Administrator. Review of the list of current residents identified as an elopement risk revealed there were 6 residents identified on a laminated paper. The pictures were posted of the residents on this list. Residents #4 and Resident #5, identified as an elopement risk, were observed pacing the Memory Care Unit halls on , ... and . These residents were observed being constantly redirected by staff. It was observed these 2 elopement risk residents were not wearing any identification on their person. Review of the written statement completed by RCC Staff A, documented the events of the	A 032		

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	AL11969122	A. BUILDING: _____ B. WING _____	01/21/2022

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A 032	Continued From page 14 elopement on . . . . The statement stated Staff C notified RCC Staff A that Resident #1 had finished his lunch and then she advised her that she could not locate him. Two staff (unidentified) were searching for the resident. The police returned the resident to the facility while the search was on-going. He was provided with a private aide. He was discharged to another local ALF on . . . . . . On . . . . . at 4:00 PM, an interview was conducted with the Administrator who acknowledged the findings of the elopement of Resident #1. She stated she had been working on a plan of correction. Class III	A 032		
A 165	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 resident's condition and results in:	A 165		

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A 165	Continued From page 15 1. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) [illegible], neglect, or [illegible] must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459,	A 165		

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A 165	Continued From page 16 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 interview and record review, the facility failed to complete and submit a 1-day and 15-day Adverse Incident Report to the State agency, for an incident involving a [redacted] resident, Resident #1, residing in the secured Memory Care Unit, who eloped and who was later located by local Law Enforcement.	A 165		

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A 165	Continued From page 17 The findings included: On at 9:25 AM, during an interview conducted with the Administrator, she stated on at around 4:00 PM, after Resident #1 finished eating in the dining room, caregiver Staff C alerted her that Resident #1 was missing from the Memory Care Unit. The Administrator stated she had determined Resident #1 had jumped over the chain link fence to exit the Memory Care Unit. The Administrator stated she did not have any surveillance cameras in that section of the building. She stated the staff searched the facility and surrounding areas in the community and the resident was returned in approximately 40 minutes by local law enforcement who had inadvertently located the resident. She further stated she did not call law enforcement, or the resident's family, because the resident reappeared within a reasonable timeframe. She stated after this incident, they provided a 1 to 1 caregiver to watch him until he was discharged to a more secured Memory Care Unit located in another assisted living facility. During the interview conducted on at 9:25 AM, a request was made to the Administrator to provide the 1-Day and 15-Day Adverse Incident Report she submitted to the State agency detailing this incident. The reports were not forthcoming at this time. On . . . . . , the Administrator produced the preliminary Adverse Incident Report which was dated as submitted to the State agency on at 1:41 PM. Checked off under 'Outcomes' documents 'An event that is reportable to law enforcement or its personnel for investigation' and 'Resident elopement, if the elopement places the resident at risk of harm or	A 165		

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A 165	Continued From page 18 injury.' The report provided details of the elopement incident for Resident #1 which occurred on [redacted], however it was not completed in it's entirety, missing critical information to include an analysis of the incident and any corrective actions taken to prevent recurrence of the incident. Review of the Resident Health Assessment (AHCA 1823 form) dated [redacted] for Resident #1, revealed Resident #1 was admitted to the facility on [redacted] with diagnoses to include [redacted], and [redacted]. Resident #1 was alert and oriented x 1 and was independent with all his activities of daily living except bathing. He required daily reminders for important tasks and daily observations of his whereabouts and wellbeing. Resident #1 was documented an being an 'Elopement Risk.' On [redacted] at 4:00 PM, during an interview conducted with the Administrator, she stated she did not know she needed to complete the Adverse Incident Reports at the time of the incident because Resident #1 was only missing for about an hour. Class III	A 165		