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
	AL11942783	A. BUILDING: _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FELLOWSHIP HOME AT THE FAIRWAY	5959 SUN N' LAKE BLVD. SEBRING, FL 33872

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A 000	Initial Comments A complaint investigation (complaint number: 2022010447) and a generator monitoring were conducted at Fellowship Home at the Fairway on [redacted] and [redacted]. Deficiencies were identified at the time of survey.	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 [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 [redacted] 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) Monitoring of the quantity and quality of	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 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to provide personal supervision and oversight required for each resident, to include awareness of safety, well-being, and whereabouts for ten Residents (#1, #2, #3, #4, #5, #6, #13, #14, #15, and #16) of ten sampled residents. The lack of oversight and awareness of Resident #1's whereabouts led to the Resident #1 not receiving food, fluids, medications, and care for more than 25 hours before the facility realized he was on the premises. Resulting in Resident #1 lying on a hot, tile floor on the outdoor patio bathroom and had to be hospitalized for . The lack	A 025		

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A 025	Continued From page 2	A 025		

of resident supervision procedures placed 82 in-house residents at imminent risk of serious harm or injury (photographic evidence obtained).

Findings Included:

A review of an incident report for Resident #1, conducted on , revealed that there was an error on the facility's communication log that reflected Resident #1 was out of the facility with family on . Resident #1 was found by Staff C, maintenance worker, on the concrete floor of the outside patio restroom on at 5:40pm. Resident #1 was sent to the hospital for evaluation due to his injuries.

During an interview with Resident #1's family, conducted on at 10:15am, the family member stated that Resident #1 had not recovered from severe that he sustained during the incident. The family member stated that an unknown staff member wrote Resident #2's room number on the communication log. Resident #2 was the resident away from the community with family. Resident #2 was Resident #1's next-door neighbor. The family member stated that Resident #1 goes to the patio frequently and that there was a restroom that had no air conditioning. The maintenance man was doing a check on the restroom and found Resident #1. The family member stated that Resident #1 sustained severe and had bangs, , and scratches all over his body.

A record review for Resident #1, conducted on , revealed that Resident #1 was admitted to the facility on and into hospice services on . Resident #1's most recent health assessment dated

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A 025	Continued From page 3 stated that Resident #1 had the following diagnoses: , , , and . He ambulated with a rolling walker assistive device and as needed for . Resident #1 required supervision with eating, toileting, and transferring and assistance with ambulation, bathing, and grooming. Resident #1 was a risk. Further review of Resident #1's health record conducted on revealed on , Resident #1's primary care provider's visit report stated that the resident was at risk for , , , clots, loss, , and . A review of the hospital visit report for Resident #1, conducted on , revealed that Resident #1 arrived at the emergency department of a local hospital on at 06:17pm to be evaluated from a . The report stated that Resident #1 was last seen six hours prior to being found in the pool house bathroom on his left side. Resident #1 sustained the following injuries from the due to the pressure of lying on a concrete floor for an unknown amount of time. - , - , (elevated indicative of) - Pre- Azotemia (failure) - Rhabdomyolysis (breakdown of due to director or indirect injury which may be dangerous or life threatening) which was likely a direct result due to the - Lactic Acidosis secondary to Rhabdomyolysis - Significant and , to the left , - exacerbation - Acute , Injury	A 025		

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A 025	Continued From page 4 - Elevated Troponin levels at critical levels which was related to injury and not cardia related - - Mild left and ethmoid (of these sinuses which can cause breathing difficulties) - Extensive soft tissue findings which included: o Some superficial skin loss at the left should and left anterior o Extensive and of the left and o Pressure injuries to the skin (left , and) o Moderate size left and o and at left and forehead and left cheek o Full thickness (2cm x 3cm) at the left anterior wall near the anterior clavicular line which corresponded with a pressure area over a o Marked pressure indentation on the left lateral and o Some pressure indentations and on the right medial Further hospital record review conducted on revealed the hospital was told by emergency personnel that facility staff stated that Resident #1 was last seen on at approximately 12:00pm prior to being found in an outdoor and non-air-conditioned restroom on at 5:40pm. The emergency personnel found Resident #1 lying on the hot tile floor of the outdoor restroom. Resident #1 was discharged from the local hospital to a Hospice House on at 05:39pm. A review of past temperatures for the same zip	A 025		

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A 025	Continued From page 5 code of the facility at www.timeanddate.com/weather/usa/sebring/historic, conducted on . . . . . , revealed that on at 12:00pm the temperature was 97 degrees Fahrenheit with a 49% humidity. On at 06:00pm, the temperature was 86 degrees Fahrenheit with an 88% humidity. On at 08:00am, the temperature was 88 degrees Fahrenheit with a 90% humidity. At 12:00pm, the temperature was 93 degrees Fahrenheit with a 52% humidity. At 06:00pm, the temperature was 84 degrees with an 87% humidity. During observations, conducted on . . . . . at 01:29pm, the temperature inside the restroom with the door closed was measured with a hygrometer. The temperature was 87.2 degrees Fahrenheit, and the humidity was 52.9%. There were no windows, , air flow, cooling device, or devices in the restroom to call for help. The cement floor was warm to touch. The restroom was dirty with what appeared as , dirt, bugs, and other filth on the floors, toilet, walls, and sink. There was a strong odor of in the restroom and the conditions were , humid, and uncomfortable. A review of Resident #1's incident report and investigation on at 05:40pm, conducted on . . . . . , revealed that the facility initiated emergency response via telephoning 911 when Resident #1 was found on floor in the patio restroom by Staff C. The immediate intervention for prevention was that they had made all appropriate notification. There were no interventions implemented to prevent a reoccurrence of the event. A review of Resident #1's medication observation	A 025		

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records, conducted on revealed he did not receive any medications after 02:00pm on . All medications on at 05:00pm, 07:00pm, 08:00pm, 09:00pm, and 10:00pm were circled as not given. All medications on at 06:00am, 09:00am, 02:00pm, and 05:00pm were circled as not given. The reason noted for the medications not given to Resident #1 was that the resident was out of the facility with family.

A review of the list of current in-house residents, conducted on , revealed that there were discrepancies identified with the list of current in-house residents. Residents #13 and #14 were not listed as current in-house residents but were in the facility. Residents #15 and #16 were listed as in-house but were out of the facility.

A review of the facility's communication log, conducted on , revealed that the report was set up for staff to include the date and day of the report and the residents that were hospitalized, on leave of absence, or expired at the top of the page. The observation notes were to include the residents' apartment number and the residents' name and the observation or changes in condition. There were discrepancies of residents' whereabouts on the communication log and discrepancies when the communication log was compared with the sign in and out log.

- The communication log noted that on Resident #2 was out of the facility. Resident #2's last name was noted with her room number. However, it was clear that Resident #2's room number was written overtop of Resident #1's room number.
- On , Resident #6 was noted as out with her son. There were no times noted for leaving or returning.

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A 025	Continued From page 7 - On . . . . . through . . . . . , Resident #1 was noted as hospitalized. There were no other notations that Resident #1 was out of the facility from /20222. - On . . . . . , it was noted that Resident #5 went out with family but there was no evidence of her return to the community. - On , it was noted that Resident #4 was at a doctor . . . . . but there was no evidence of his return to the community. - On . . . . . , it was noted that Resident #3 was out with his daughter but there was no evidence of his return to the community. A record review of the sign in and out log, conducted on , revealed the following discrepancies as compared with the communication log: - Resident #1 had not signed out of the facility on or . On , there was a notation that Resident #1 had signed into the community at 12:45pm but there was no date and time of his departure. Furthermore, Resident #1 became missing from the community on . . . . . and was found in an outside patio restroom on and sent to the hospital. Resident #1 never returned to the facility to be able to sign into the community. - On . . . . . , Resident #2 did not sign out of the community. - On . . /20222, Resident #6 did not sign out of the community. - On . . . . . , Resident #5 did not sign out of the community. - On . . . . . , Resident #4 did not sign out of the community. - On . . . . . , Resident #3 signed out at an unknown time and there was no evidence of his actual return to the facility.	A 025		

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A 025	Continued From page 8 A review of the undated resident sign in and out policy, conducted on , revealed that before leaving the community, residents were asked to sign out to ensure that staff knew the number of residents in their care and the location of the residents who were away from the community. Residents that were planning to remain overnight were asked to notify the wellness office. The sign in and out log was located at the front desk and in Building C's lobby. During an interview with Staff C, Maintenance Worker, conducted on at 11:26am, Staff C stated that on , he had to take a resident to a doctor's , , , and he went to the outside patio restroom to use the restroom before the transport at approximately 05:45pm. Staff C stated that when he opened to restroom door, he saw Resident #1 lying on the floor and the resident mumbled something and he (Staff C) ran to get help. Staff C stated that there were no windows, fans, or air conditioning in the two outside patio restrooms and that the floor was concrete. Staff C stated that some residents that sit on the patio know that the restrooms are there, but most staff and residents do not know that the restrooms are there. Staff C stated that there were no scheduled checks for the outside patio restrooms. Staff C stated that he did not know the facility's policy and procedures for elopements or missing person and had not been trained for these situations. During an interview with Staff D, Resident Care Aide, conducted on at 12:04pm, Staff D stated that she worked from 07:00am through 03:00pm on and that she performed every two-hour check on all her residents which included Resident #1. She stated the last time	A 025		

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A 025	Continued From page 9 she observed Resident #1 was on . . . . . at 02:00pm. Staff D stated that the communication log had Resident #1 out of the facility, but it was the wrong room number. During an interview with Staff H, Medication Technician (Med Tech), conducted on . . . . . at 02:51pm, Staff H stated that on Staff G, Med Tech, was looking for Resident #1 to give him his medicine. Staff G called over the walkie-talkie and asked if anyone had seen Resident #1. Staff H stated that she responded to Staff G and told her to check the . . . patio. Staff H stated that on at approximately 06:30pm, Staff G had told her that Resident #1 was not on the patio. Staff H stated that she told staff G that sometimes Resident #1 goes out of the facility with his daughter. Staff H stated that on . . . . . , Staff A and herself were working in Building C when Staff C ran in telling them that a man was on the floor in the restroom. Both Staff H and Staff A followed Staff C to the outside patio restroom. When Staff C opened the door, they saw that it was Resident #1. Staff A then called emergency response via 911. Staff H stated that Staff F was the last person to give Resident #1 his medications on . . . //2022. Staff H did not understand the reason that they did not press harder to find Resident #1 when they first could not find the resident. Staff H stated that they said Resident #1 left with his son earlier, but no one told us that the resident was gone. Staff H did not clarify who 'they' were. During an interview with Staff A, Med Tech, conducted on at 02:59pm, Staff A stated that she did not work on . . . . . but was working on the 03:00pm through 11:00pm shift on . . . when Resident #1 was found. Staff A stated that at the start of her shift on	A 025		

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A 025	Continued From page 10 . . . . . she noticed that Resident #1 was not in the facility and asked Staff F of his whereabouts. Staff F told Staff A that she had not seen Resident #1. Staff A stated that on . . . . . Staff C came in running into the dining room from the patio saying that there was a man in the bathroom. Staff A stated that she did not know there were restrooms out on the patio. During an interview with Staff G, Med Tech, conducted on at 03:05pm, Staff G stated that on . . . . . she was working in Building B on the 03:00pm through 11:00pm shift. Staff G stated that she was unable to find Resident #1 to assist him with his 05:00pm medications at approximately 05:20pm. She asked the resident care aid (not named) from Building B and was told that Resident #1 was out with his daughter. Staff G also asked two dining staff (not named) and they said that Resident #1 was probably out with his daughter. Staff G stated that she checked the sign out book and did not find that Resident #1 was signed out. Staff G stated that a lot of residents leave the community and do not sign out and that Resident #1 probably did not sign out. Staff G stated that no one looked/searched for Resident #1, and no one called Resident #1's daughter to verify his whereabouts. Staff G stated that most residents in the facility were checked on every two-hours. Staff G stated that the facility needed more communication between the staff about residents. During an interview with Staff F, Resident Care Aide, conducted on at 03:16pm, Staff F stated that she passed medications to Resident #1 on at 02:00pm. Staff F stated that on at an unknown time, a staff person called on the walkie-talkie inquiring the	A 025		

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whereabouts of Resident #1 and another staff person responded that he was signed out with his family. Staff F did not remember who called or who responded to the call. Staff F stated that a Hospice aide was looking for Resident #1 on early in the morning and that they were told he was with his family. I did call Resident #1's son and daughter but neither one answered the phone. Staff F stated that no staff was assigned to check the outside patio restrooms and that she did not know the restrooms were out there until Resident #1 was found out there. Staff F stated that residents and family don't always follow protocol with signing in and out. Staff F stated that all residents were checked on at least every two-hours and some residents need more frequent checks than every two-hours.

During an interview with the Executive Director, conducted on at 03:45pm, she agreed that the facility did not immediately search for Resident #1 when he was missing on .

During an interview with the Administrator, conducted on at 04:05pm, the Administrator stated that the missing person policy and procedures was the same as the elopement policy and procedures and agreed that staff did not initiate an immediate search and assumed that Resident #1 was with his family. At 07:30pm, the Administrator stated that the list of residents was a list that she devised to keep track of residents and agreed that the list of residents did not include all current residents (Residents #13 and #14) and did not note that Residents #15 and #16 were out of the facility.

During an interview with the Executive Director on

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A 025	Continued From page 12 . . . . . at 08:00pm, she stated that the education regarding the facility's resident sign out policy was given to staff and that this was just a start and was not completed and no other education to staff of changes in policies had been initiated. During an interview with Staff E, Med Tech, conducted on . . . . . at 03:50pm, Staff E stated that he was working in Building B and was told that Resident #1 was out of the facility with his family on . At an unknown time after supper, Staff A asked Staff E if Resident #1 was and Staff E responded that Resident #1's lunch and supper had not been touched. It was a short time after this, all staff were rushing outside. Staff E stated that when he approached Resident #1 lying on the cement floor down in the outside patio restroom, the resident was mumbling and not making sense. Staff E stated that Staff A called emergency personnel via 911. Staff E stated that himself and Staff A tried to build a timeline of how long the resident was missing and how long that he may have been laying there. Staff E stated that the more they looked at sign in and out log, medication observation records and the further they went , they realized that they were unable to determine how long Resident #1 had been in the outside patio restroom. Staff E stated that Staff I had told him that the resident was with his daughter, and he was not signed out. Staff E stated that he was one of the few staff or residents that knew those restrooms were out there and if it hadn't been for Staff C stopping to use the restroom, we wouldn't have found Resident #1 until we smelled him. Staff E stated that the outside patio restrooms were not monitored. Staff E stated that all residents were to be checked on every two hours. Staff E stated	A 025		

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A 025	Continued From page 13	A 025		

that family just show up and take resident out of the facility without signing them out and that staff assume that residents are out with their families and that there was no further investigation.

On at 04:35pm, the facility provided video footage of the outside patio area where Resident #1 was located on . Previous interviews with facility staff and hospital record review on indicated that Resident #1 was missing for six hours. After review of the video footage, it was determined that Resident #1 was missing from at 4:20 PM until found on at 5:40 PM (25 hours later).

On at 04:35pm A review of the patio video footage revealed that on at 04:20pm, Resident #1 was on the patio sitting at a table near the dining room entrance. Resident #1 got up from the patio table and walked to the outside patio restroom with his wheeled walker. Resident #1 was not wearing at the time. Resident #1 opened the door to the restroom and went inside. There was no further activity on the patio until . On at 05:40pm when Staff C walked onto the patio from the dining room. Staff C had a drink in his right and walked over to the patio from the dining room. Staff C had a drink in his right and walked over to the patio edge, took a drink, and walked to the table near the dining room entrance and placed the drink on the table. Staff C went to the outside patio restroom, opened the door at 05:41pm. Staff C stood for a second and then went inside. A second later, Staff C ran out of the bathroom into the dining room entrance. At 05:43pm, Staff C led Staff A, H, E, and B to the restroom. Staff A and B went inside the restroom first and Staff A ran to a cellular phone on the patio table and appeared to

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A 025	Continued From page 14 dial number on a cellular telephone. Emergency personnel arrived at 05:51pm. During an interview with the Executive Director and Administrator, conducted on [redacted] at 04:35pm, the Executive Director and Administrator agreed that the date and time stamp on the video feed were correct, and that Resident #1 went into the outside patio restroom on [redacted] at 04:20pm. The Administrator stated there are no camera screens and the video feed goes into a system and the Administrator and Executive Director can pull it up on their computer. The Administrator also stated that the video feed was referred to after an incident has occurred and not throughout the day. The Executive Director and Administrator agreed that Staff C just happened to go into the outside patio restroom to use the restroom and was not performing a spot check on the restroom on [redacted] at 05:40pm when Staff C found Resident #1 lying on the hot cement floor. Class I	A 025		
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	A 032		

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A 032	Continued From page 15	A 032		

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 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

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A 032	Continued From page 16 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, record review, and interview, the facility failed to maintain detailed facility resident elopement response policies and procedures that included identification of specific staff responsible for the implementation of each part of the elopement response and which staff were responsible for making notifications. Additionally, the facility failed to conduct and document resident elopement drills to include all administration and direct care staff participation in the drills. Furthermore, the facility failed to conduct an immediate search of the premises when one Resident (#1) was missing for greater than twenty-five hours and was found on the premises lying in an outside bathroom on the hot cement floor and sustained life-threatening injuries. Findings Included: A review of Resident #1's hospital visit report, conducted on , revealed that Resident #1 arrived at the emergency department of a local hospital on at 06:17pm to be evaluated from a . . The report stated that Resident #1 was last seen six hours prior to being found in the pool house bathroom on his left side. Resident #1 sustained extensive life-threatening	A 032		

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A 032	Continued From page 17 injuries from the . due to the pressure of lying on a concrete floor for an unknown amount of time. The hospital visit report stated that the facility staff told emergency personnel that Resident #1 was last seen on . . . . . at approximately 12:00pm prior to being found in an outdoor and non-air-conditioned restroom. The emergency personnel found Resident #1 lying on the hot tile floor of the outdoor restroom. Resident #1 was discharged from the hospital to a Hospice House on . . . . . at 05:39pm. A review of Resident #1's medication observation records, conducted on revealed he did not receive any medications after 02:00pm on . The medications circled as not given to Resident #1 on . . . . . and . . . . stated that the resident was out of the facility with family. A review of the undated elopement policy and procedures, conducted on , revealed that residents without a history of . . . and/or elopement risk were to be accounted for at least every two hours every day and that residents were to sign in and out when leaving the facility. The elopement response policy and procedures stated that all staff would receive elopement training and that the facility would be conducted two elopement drills every year. The elopement response policy and procedures did not identify specific staff responsible for the implementation of each part of the elopement response and which staff were responsible for making the appropriate notifications. A review of the facility's documented elopement drills, conducted on , revealed that the facility conducted one elopement drill in the year 2022 which was on at 10:00am with	A 032		

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A 032	Continued From page 18 seven employees in attendance. The facility conducted one elopement drill which was on [redacted] at 01:20pm with six employees in attendance. The facility conducted two elopement drills in 2020 which were on [redacted] at 09:30am and [redacted] at 04:40pm. There were eight employees in attendance with each of these elopement drills. A review of the list of staff, conducted on [redacted], revealed that there were fifty-eight direct care employees employed at the facility. This list did not include the administrative staff. During interviews with Staff A, Staff C, Staff F, Staff G, Staff H, conducted on [redacted] at between 11:26am through 03:16pm and with Staff E on [redacted] at 03:50pm, Staff A, Staff F, and Staff H stated that they were unaware that there were two restrooms outside on the patio. Staff A, Staff C, Staff E, Staff F, and Staff H stated that there were no routine checks or monitoring of the outside patio restrooms. Staff A, Staff C, Staff E, Staff F, Staff G, and Staff H stated that there was not an immediate search of the facility/premises for Resident #1 when he became missing on [redacted]. Staff C and Staff G stated that they had not been trained in the facility's elopement response policy and procedures. During a review of the facility's security video feed, conducted on [redacted] at 04:40pm, the video feed showed Resident #1 walking to the outside patio restroom on [redacted] at 04:20pm. There was no activity on the [redacted] patio until [redacted] at 05:40pm when Staff C entered the restroom and found Resident #1 lying on the cement floor. The resident was missing for twenty-five hours and twenty minutes.	A 032		

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A 032	Continued From page 19 During an interview with the Executive Director and Administrator, conducted on , from 03:45pm through 07:30pm, the Executive Director agreed that the facility did not immediately search for Resident #1 when he was missing on . The Executive Director agreed that all facility administrative and direct care staff were not included in the facility elopement drills. The Administrator stated that the missing person policy and procedures was the same as the elopement policy and procedures and agreed that staff did not initiate an immediate search and assumed that Resident #1 was with his family. The Executive Director and Administrator agreed that the date and time stamp on the video feed were correct, and that Resident #1 went into the outside patio restroom on at 04:20pm. The Executive Director and Administrator agreed that Staff C just happened to go into the outside patio restroom to use the restroom and was not performing spot checks on the restroom on at 05:40pm when Staff C found Resident #1 lying on the hot cement floor. Class II	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	A 056		

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A 056	Continued From page 20 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. (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	A 056		

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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,
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 provide prescribed medications (meds) as ordered and failed to notify their primary care

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A 056	Continued From page 22 providers (PCP) when the residents refused their meds or when the meds were not available for them to take for two Residents (#1 and #12) of two sampled resident that required assistance with self-administration of meds. Findings Included: A review of Resident #1's medication observation records (MORs), conducted on , revealed that Resident #1 had meds that were circled as not given to the resident which included: - -S 8.6-50mg was circled as not given on at 09:00pm because the resident was out of the facility. - 1mg was circled as not given on at 07:00pm because the resident was out of the facility. - 300mg was circled as not given on at 02:00pm because the resident was not in his apartment. - 2.5mg was circled as not given on at 05:00pm because the resident was out of facility. - 40mg was circled as not given on at 09:00am because the resident refused the med. - 500mg was circled as not given on at 2:00pm and 10:00pm; at 06:00am, 02:00pm, and 10:00pm; and at 06:00am because the med was not available. There was no evidence in Resident #1's record that his PCP was notified that he was not taking his prescribed meds as ordered. A review of Resident #12's MORs, conducted on 07/, revealed that Resident #12's 0.25mg was circled as	A 056		

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A 056	Continued From page 23 not given from . . . . . through . . . . . because the resident refused the med. There was no evidence in Resident #12's record that his PCP was notified that he was not taking his prescribed meds as ordered. During an interview with the Wellness Director, conducted on at 07:40pm, the Wellness Director was unable to provide evidence that Residents #1 and #12's primary care providers were notified that the residents were not receiving their prescribed meds as ordered. Class III	A 056		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of	A 081		

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A 081	Continued From page 24 completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of	A 081		

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A 081	Continued From page 25 compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty	A 081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942783	A. BUILDING: _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 081	Continued From page 26 (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide direct care staff with the required in-service trainings, which included a two-hour pre-service orientation prior to interacting with residents and trainings for elopement response and activities of daily living and behavioral needs within thirty-days of hire for two employees (Staff C and E) of five sampled employees. Findings Included: A record review for Staff C, conducted on , revealed that Staff C's employee record did not contain evidence that the employee had completed training for elopement response within thirty days of employment. Staff C was hired on . A record review for Staff E, conducted on ., revealed that Staff F's employee record did not contain evidence that the employee had completed a two-hour pre-service orientation training prior to interacting with residents or a three-hour training for activities of daily living and behavioral needs within thirty days of employment. Staff E was hired on .	A 081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 081	Continued From page 27 During and interview with the Administrator, conducted on , the Administrator agreed that Staff C's employee record did not have evidence that the employee completed training for elopement response within thirty days of employment. The Administrator agreed that Staff E's employee record did not contain evidence that the employee had completed a two-hour pre-service orientation training prior to interacting with residents or a three-hour training for activities of daily living and behavioral needs within thirty days of employment. Class III	A 081		
A 090 SS=D	59A-36.011(11) FAC Training - (11) . . . . . TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to provide the one-hour required training regarding the facility's policy and procedures regarding . . . . . (. . . .)	A 090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 090	Continued From page 28 within 30-days of hire for one employee (Staff D) of five sampled employees. Findings Included: A record review for Staff D, conducted on . . . , revealed that there was no evidence in Staff E's employee record that the employee had completed a one-hour training for the facility's policy and procedures for within 30-days of employment. Staff D was hired on . . . . During an interview with the Administrator, conducted on at 04:36pm, the Administrator agreed that Staff D's employee record did not have evidence that the employee completed a one-hour training regarding the facility's policy and procedures for within thirty-days of employment. Class III	A 090		