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
	AL11932659	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT A PACIFICA SENIOR LIVING COMMUNIT	3207 NORTH MONROE STREET TALLAHASSEE, FL 32303

(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 investigation (complaint #2023001852) was conducted at Woodmont A Pacifica Senior Living Community on ..... through ..... . The facility had deficiencies at the time of the survey. On , the facility had a census of 48; 13 of which were memory care residents. The following Class I deficiency was identified on : A0025 - Resident Care - Supervision. The facility failed to maintain awareness of a resident's whereabouts which resulted in resident #1, who has a diagnosis of ....., history of ..., and a care plan for exit seeking, being found on the ground in the facility's secured courtyard in the early morning hours of . The facility was unable to determine how long the resident had been in the courtyard as the door alarms had not been working for several months and the last documented interaction with the resident was on ..... at 7:31 PM, during assistance with self administration of mediations.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of ..... or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such ..... or , ... The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the	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	A 025		

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 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

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A 025	Continued From page 2 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 observations, record review, interviews, and policy review, the facility failed to appropriately supervise residents by failing to maintain awareness of a resident's whereabouts which resulted in resident #1 being left unattended for an unknown period of time in the facility's secured courtyard, for 1 of 4 sampled residents (Resident #1). The findings include: A review was conducted of a facility provided occurrence report which states that on at 7:45 AM, resident #1 was "observed outside in courtyard on ground laying on right side. Staff assisted resident to chair upon assessment resident complained of left (Emergency Medical Services) called". Further review of the investigation revealed a handwritten note with Staff Member D's, a Medication Technician (MT), name written at the top and the date written at the bottom of the page. The note states, "Came into work at 6:20 (AM) my aid came in before me, neither of us was given report. Pervious staff was gone. Got ready to do room rounds about 7:30 (AM) to get up patients for breakfast and aid from AL (assisted living) told us a patient from AL seen out her window a patient on the ground. We ran out to the patio (courtyard) to see the [resident #1] on the ground, I sat her up to get next recommendations we call (staff Member H, Licensed Practical Nurse/Resident Care Director)	A 025		

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A 025	Continued From page 3 at 8:00 AM, then called ambulance and family. Its a normal tendency the [resident #1] who , walks around and has multiple times." A review of medical record for resident #1 revealed the resident was admitted to the facility's memory care unit, located on the 2nd floor, on . The memory care unit is a secured unit that has access to a secured courtyard. Review of the Resident Health Assessment for Assisted Living Facilities, Form 1823 dated revealed the resident had diagnoses of , , , , recent , , and . On page 2 of 3 under "Status" a check mark indicating "Yes" was noted next to the question "Require 24-hour nursing or care?". The medical record included a diagnosis of "aggression-psych related". A review of the "Needs and Services Plan" identified "Exit Seeking" added on with interventions to include "Monitor for and reduce triggers" and a Goal "Environmental contributors to exit seeking will be identified and reduced". Resident #1 required supervision with ambulation, bathing, , eating, self-care/grooming, toileting and transferring. The resident required assistance with self-administration of medications. The last documented interaction with resident #1 prior to her being found in the courtyard was on at 7:31 PM, when Staff Member D, MT, documented assisting the resident with her evening medications that included (for treatment of) 10 mg (milligrams) (an) and 25 mg and (high) 180 mg. A review of the Shift Report and early warning tool dated for day shift documented that "resident was found outside laying on the ground" no other shift reports were provided by the facility for	A 025		

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A 025	Continued From page 4 resident #1. There was no documentation to include narrative charting documentation, progress notes or rounding reports in the record identifying the incident that occurred on . A review of hospital records for resident #1 revealed that on at 8:47 AM, the resident was brought to the emergency department (ED) via emergency medical services ( ) after being found on the ground in the courtyard of the Memory Care Unit. Per , the resident was alert and said she but did not give more details and did not remember how. Per records, the call came at 8:00 AM and arrived at the facility at 8:12 AM. On the hospital listed diagnoses of "advanced with , mildly displaced , deconditioning secondary to ." On the resident was discharged from the hospital to a skilled nursing facility. On beginning at approximately 6:55 AM, a tour of the facility was conducted with Business Office Manager (BOM). During the tour, an alarm door labeled "trans Stairwell" was tested and did not alarm. The BOM stated that the door alarms are set to be armed from 8:30 PM to 8:30 AM. She stated that she was unsure why the door did not alarm. The BOM stated the facility has not had maintenance staff since , and that all staff "chips in". On at approximately 6:35 AM, an interview was conducted with the Resident Care Director (RCD), who stated that the facility has rounding sheets to document residents' whereabouts every 2 hours. No rounding sheets were provided upon request, instead, RCD provided forms titled "End of Shift Report". During a follow-up interview	A 025		

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A 025	Continued From page 5 conducted on . . . . . at 7:59 AM, the RCD was asked about incident involving resident #1. During the interview the RCD stated that she did not witness the incident. RCD stated staff reportedly found resident #1 on the ground in the courtyard and she directed them to call Emergency Medical Services for evaluation. On . . . . . at approximately 8:53 AM, an interview was conducted with Staff Member D, MT, during which he indicated he was assigned to the Memory Care Unit on on the first shift (6:00 AM to 2:00 PM) and arrived to the unit around 6:20 AM. Staff Member D stated he did not perform a shift report and thought the resident was in her room. Staff Member D, MT, indicated he was unaware of resident #1's whereabouts until Staff Member B, MT, and Staff Member E, MT, who were working in another unit made him aware that the resident had been seen outside on the ground. Staff Member D, MT, confirmed resident #1 was unsupervised in the courtyard. On . . . . . at 2:18 PM, a follow-up interview was conducted with Staff Member D, during which he stated the facility's alarms had not been working for 3 months and that they would have alerted the night shift of any residents exiting the Memory Care Unit to the courtyard. On at approximately 10:23 AM, a telephone interview was conducted with resident #1's Power of Attorney (POA). The POA stated he had concerns about the length of time his mother was left in the courtyard alone and that his mother had a piece of plastic inside her . . . with dirt and grass that was removed in the ED. On at approximately 11:05 AM, during a telephone interview with Staff Member B, MT, she stated that she worked on on first shift	A 025		

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A 025	Continued From page 6 (6:00 AM -2:00 PM) . Staff Member B indicated she was assigned the Assisted Living side and was bringing breakfast trays inside residents rooms along with Staff Member E, a MT. Staff Member B entered Resident #3's room and the resident alerted her that resident #1 was in the courtyard and had been there all morning. Resident #3's window had a view of the Memory Care Unit courtyard. Staff Member B looked out resident's #3's window and saw resident #1 in a sleeping position on the ground fully clothed with jeans, shoes and long sleeves. Staff Member B stated she went to the Memory Care Unit and asked Staff Member D if he knew where resident #1 was and Staff Member D responded resident #1 was in her room. At this point, Staff Member B made Staff Member D aware resident #1 was in the courtyard. On at approximately 12:15 PM, an interview was conducted with Staff Member I, MT. Staff Member I reported, "We don't really have a rounding sheet. We used to. But we haven't had one in a long time. We have an End of Shift report sheet with our assigned areas on them. We document what we do for residents on it. But we don't document on every resident we round on. We just got a new form today to start using. We have never used it before. It is brand new". On at approximately 2:10 PM, a follow-up interview was conducted with Staff Member D. Staff Member D stated, "i got to the floor around 6:30 AM on the 31st. I clocked in at 6:24 AM. The night shift person, (Staff Member A) clocked out at about 6:05 AM. She was already sitting downstairs waiting on her Uber driver to come and pick her up. There should have been my orientee on the floor waiting on me. But I am not sure. I usually get (resident #1)	A 025		

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A 025	Continued From page 7	A 025		

up around 7:30 AM or 8:00 AM. I did not round on her right when I got to the floor that morning. I know I should have done my own "little" check and I didn't". Staff Member D stated that he takes another staff member with him to "Get her up because she will fight you. So, you must be patient and gradual with her. When I round on my residents, I document what care I do to them. It is written on a report sheet. I was notified that resident #1 was outside by another staff member. That staff member was notified by a resident that had her window open. We then ran outside to help her. We got her up and then called our Administrator. She told us to send her to the hospital. When resident #1 is up, she roams around all day. She does go into the courtyard. But I will tell you, when I put her to bed, say like at 9 PM, she will stay where you put her. All I'm saying is that she was outside from anywhere between midnight and when I found her". Staff Member D reported that resident #1 "stumbles when she walks". Staff Member D stated that resident #1 had been "stumbling for a while". Staff Member D stated, "When I found her (Resident #1), she was "casually" laying on the ground. She wasn't dirty that I saw. I did not see any dirt or grass on her. There are door alarms here and the one to the courtyard was working but it has not worked for about three months. We would know if she was outside if the alarms on the doors were working".

On ... . at approximately 4:00 PM, an interview conducted with the Executive Director (ED) revealed that she had spoken with the alarm company. The ED stated that the alarm company was able to "fix the alarm over the phone". The ED stated that she was never informed the alarms were not working. The ED reported that an alarm , and door were "reset" on the third

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A 025	Continued From page 8 floor, that had been open. The ED also stated the "door to the courtyard on the second floor was "reset" to alarm at 8:30 PM". The ED provided the alarm map and policy/protocol regarding alarm times. On ..... at approximately 4:04 PM, a telephone interview was conducted with Staff Member E, MT. Staff Member E, MT stated she worked on during first shift (6:00 AM - 2:00 PM) and was assigned to work on the Assisted Living side. Staff Member E stated she witnessed Staff Member B, MT telling Staff Member D, MT about resident #1 being in the courtyard. Staff Member E stated Staff Member D, MT, did not know resident #1 was outside. During the interview, Staff Member E stated she was not aware of any door alarms at the facility. On at approximately 4:15 PM, an interview was conducted with resident #3. Resident #3 reported seeing resident #1, "laying in between the brick wall and the air conditioner. Resident #3 stated, "I have told them for a long time that she gets in the corner over here. No one would listen to me. I have asked them who she was and if they would ask her to stop coming over by this window". Resident #3 stated she was informed by the previous Executive Director to "just close my shades". Resident #3 stated, "I noticed her laying there on the ground between the brick wall and air conditioner as the sun was coming up. She was eating dirt and mulch when I saw her. I hollered at someone to come into my room and told them that she was laying out there. They took off running to go and help her. There is one girl that works on night shift that will come around every couple of hours. But then she has been off the last couple of nights, and I haven't seen anyone".	A 025		

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A 025	Continued From page 9 On at approximately 4:40 PM, a telephone interview was conducted with Staff Member G, a MT. She indicated she worked on first shift (6:00 AM-2:PM). Staff Member G indicated she was assigned to work in the Memory Care Unit with Staff Member D, MT. Staff Member G, MT stated she arrived to the unit around 6:00 AM. Staff Member G stated it was her second day at work and she had not been instructed to do rounds on residents. Staff Member G stated night shift staff left when she arrived to the unit without giving her report. Staff Member G stated she was not aware of resident #1's whereabouts until staff working at the Assisted Living side made her and Staff Member D aware that resident #1 was in the courtyard. On at approximately 9:27 AM, an interview was conducted with the acting Executive Director (ED) who stated the alarms had been fixed as of and staff have been in-serviced on the use of walkie talkies to communicate with each other in the case alarms are set on. The ED stated a new rounding sheet was implemented last night in which staff must document rounding on residents every two hours and off going and incoming shift giving report. On at approximately 4:21 PM, a telephone interview was conducted with Staff Member C, a Personal Care Assistant ( ). Staff Member C, , stated she worked on during third shift (10:00 PM- 6:00 AM). This staff revealed that her shift ended at 6:00 AM on . Staff Member C stated facility's alarms have not been working for about 2 months. Review of facility policy" Monitoring Residents" dated stated: "A systemic approach for	A 025		

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A 025	Continued From page 10 resident monitoring will be provided with routine staff rounds"[...]"shift overlap time or change of shift time will include and additional accounting of all residents" Review of the undated facility policy "Pacifica Woodmont Security System" revealed, "All entry/exit community doors on our assisted living, transitions and memory care are set to an intrusion alarm and will set off the alarm transmitter located at the nursing station when doors are breached between 8:30 pm and 8:30 am."[...] "The doors will be disarmed between 9:50 pm and 10:30pm and again from 5:50 am to 6:30 am to allow for shift change and rounds, staff to enter and exit the bldg. and pull any community or resident trash." A review of the facility's website (https://www.pacificaseniorliving.com/senior-living/fl/tallahassee/n-monroe-st/memory-care) revealed, "Memory Care (at the facility) is designed to meet the needs of those with , , and other memory conditions. We offer a safe environment for individuals with memory loss to live in comfort and security". Under services it states there is "24/7 Emergency Maintenance". Class I	A 025		
A 079 SS=F	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and	A 079		

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A 079	Continued From page 11	A 079		

Respite Care Residents Staff Hours/Week
0-5 168
[illegible] 212
16-25 253
26-35 294
36-45 335
46-55 375
56-65 416
66-75 457
76-85 498
86-95 539

For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.
2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and [illegible]
( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or

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A 079	Continued From page 12 courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with	A 079		

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A 079	Continued From page 13 the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs.	A 079		

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A 079	Continued From page 14 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to maintain , , ( ) certification records and ensure there was a certified staff member on shift for 24-hour coverage for 5 of 12 sampled staff members (A, D, E, G, and J). The findings include: An interview was conducted on , at approximately 6:15 AM with the acting Executive Director (ED) overseeing the facility. The Interim ED stated she began work on . She stated that on , the previous ED, "Left her keys and badge on the desk and has never returned to the facility". The Interim ED stated there is now herself and Resident Care Director (RCD) in the facility. A record review was conducted of the facility's	A 079		

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A 079	Continued From page 15 personnel files, which failed to include copies of cards for any of the 12 staff members reviewed. On , at approximately 3:15 PM, the acting ED reported that she was currently "texting" staff members for them to send to her their certifications of . At approximately 4:00 PM on , the acting ED provided copies of 7 out of 12 staff members cards. The following 5 staff members could not provide copies of current certifications: Staff Member A, Personal Care Assistant ( ) with a date of hire of , no on file. Staff Member D, Medication Technician (MT), with a date of hire , no on file. Staff Member E, Certified Nursing Assistant/Medication Technician (CNA/MT), with a date of hire , no on file. Staff Member G, MT, with a date of hire of , no on file. Staff Member J, Business Office Manager, with a date of hire of , no on file. A review of the staffing schedule was conducted for the dates - , which revealed the facility failed to provide 24-hour coverage on the following dates/times: , - No coverage from 2 PM until 6 AM. , - No coverage from 10 PM until 6 AM , - No coverage from 10 PM until 6 AM , - No coverage from 10 PM until 6 AM , - No coverage from 2	A 079		

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PM until 6 AM
- No coverage from 6 AM until 10 PM
- No coverage from 6 AM until 2 PM
- No coverage from 2 PM until 6 AM
- No coverage from 2 PM until 10 PM
- No coverage from 2 PM until 6 AM
- No coverage from 10 PM until 6 AM
- No coverage from 6 AM until 6 AM
- No coverage from 10 PM until 6 AM
- No coverage from 10 PM until 6 AM
- No coverage from 10 PM until 6 AM
- No coverage from 10 PM until 6 AM

A review of job descriptions was conducted on revealed, ( ) is required for staff members in the facility. In addition, the ED is responsible for complying with all aspects of operations, including personnel practices, in accordance with the corporate policies, federal, state, and local regulations. The ED is to ensure that adequate staffing is provided to meet resident needs, corporate standards, state requirements, and within budgetary guidelines.

On a review of the Resident Care Director (RCD) job description revealed the RCD is responsible for implementing orientation and

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A 079	Continued From page 17 education programs in accordance with the policies and procedures of the facility. The RCD is responsible for the scheduling of Personal Care Assistants, developing daily tasks, and making assignments. The RCD is also responsible for verifying employee hours on time cards and replacement staffing. The RCD is to ensure that all new employees receive general and specific job training and participate in the New Hire Orientation program. The RCD is responsible for tracking and ensuring regulatory training requirements are met for associates annually. On a review of the Business Office Manager (BOM) job description revealed the BOM is responsible for Human Resources. The BOM is to provide for the safety and security of associates and may be the community Safety Officer. The BOM is to triage associate complaints and grievances and order all state and company required pre-employment screening, such as drug tests, physicals, , clearances and/or background checks. The BOM will participate in New Hire Orientation program and prepare new hire paperwork. The BOM will provide training to department heads and act as a consultant regarding Human Resources policies. Class III	A 079		
A 152 SS=G	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,	A 152		

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A 152	Continued From page 18 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, 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, staff interviews and facility policy review, the facility failed to ensure exit alarm doors were in good working order which resulted in Resident #1 being left unattended for an unknown period of time in the facility's secured courtyard. This has the potential to affect all 48	A 152		

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A 152	Continued From page 19 residents in the facility. The findings include: On . . . . . beginning at approximately 6:55 AM, a tour of the facility was conducted with Business Office Manager (BOM). During the tour, an alarm door labeled "trans Stairwell" was tested and did not alarm. The BOM stated that the door alarms are set to be armed from 8:30 PM to 8:30 AM. She stated that she was unsure why the door did not alarm. The BOM stated the facility has not had maintenance staff since . . . . . , and that all staff "chips in". A review of the medical record for resident #1 revealed that she was a resident of the facility's locked Memory Care Unit since . Her Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823, dated stated that she required supervision in all activities of daily living (ADLs). A progress note dated signed by the Resident Care Director (RCD) stated resident #1 was observed on ground in courtyard and sent to Emergency Room for evaluation. A review of the facility provided occurrence report dated . . . . . at 7:45 AM, stated the resident was observed outside in courtyard and found lying on ground. Staff Member D, a Medication Technician (MT), wrote a statement on . . . . . as part of the facility's incident report investigation. On his statement, Staff Member D, MT, explained how on the morning of , around 7:30 AM, he was made aware that resident #1 was outside on the ground by staff working at the Assisted Living side. On at approximately 8:53 AM, an interview was conducted with Staff Member D, MT, during	A 152		

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A 152	Continued From page 20 which he indicated he was assigned to the Memory Care Unit on on the first shift (6:00 AM to 2:00 PM) and arrived at the unit around 6:20 AM. Staff Member D, MT, indicated he was unaware of resident #1's whereabouts until Staff Member B, MT, and Staff Member E, MT, who were working in another unit made him aware that the resident had been seen outside on the ground. Staff Member D, MT, confirmed resident #1 was unsupervised in the courtyard. On at 2:18 PM, a follow-up interview was conducted with Staff Member D, during which he stated the facility's alarms had not been working for 3 months and that they would have alerted the night shift of any residents exiting the Memory Care Unit to the courtyard. On at approximately 4:00 PM, an interview conducted with the acting Executive Director (ED) revealed that she had spoken with the alarm company. The ED stated that the alarm company was able to "fix the alarm over the phone". The ED stated that she was never informed the alarms were not working. The ED reported that an alarm , and door were "reset" on the third floor, that had been open. The ED also stated the "door to the courtyard on the second floor was "reset" to alarm at 8:30 PM". The ED provided the alarm map and policy/protocol regarding alarm times. On at approximately 4:04 PM, a telephone interview was conducted with Staff Member E, MT. Staff E, MT stated she worked on during first shift (6:00 AM - 2:00 PM) and was assigned to work on the Assisted Living side. Staff Member E stated she witnessed Staff Member B MT telling Staff Member D, MT, about resident #1 being in the courtyard. Staff Member E, MT stated Staff Member D, MT, did not know	A 152		

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A 152	Continued From page 21 resident #1 was outside. During the interview, Staff member E stated she was not aware of any door alarms at the facility. On . . . . . at approximately 4:21 PM, a telephone interview was conducted with Staff Member C, a Personal Care Assistant ( ). Staff Member C, , indicated she worked third shift (10:00 PM-6:00 AM). Staff Member C stated facility's alarms have not been working for about 2 months. On at approximately 9:27 AM, an interview was conducted with the acting Executive Director (ED) who stated the alarms had been fixed and staff had been in-serviced on the use of walkie talkies to communicate with each other. Review of the undated facility policy "Pacifica Woodmont Security System" revealed: "All entry/exit community doors on our assisted living, transitions and memory care are set to an intrusion alarm and will set off the alarm transmitter located at the nursing station when doors are breached between 8:30 pm and 8:30 am."[...] "The doors will be disarmed between 9:50 pm and 10:30pm and again from 5:50 am to 6:30 am to allow for shift change and rounds, staff to enter and exit the bldg. and pull any community or resident trash." Class II	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	A 165		

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A 165	Continued From page 22	A 165		

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:
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

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A 165	Continued From page 23 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) [redacted], neglect, or [redacted] 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, 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	A 165		

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A 165	Continued From page 24 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 reviews, interviews and facility policy review, the facility failed to report to the state agency an incident that involved an unwitnessed of a resident left unattended for an unknown period of time in the facility's secured courtyard and transferred to the hospital for treatment/evaluation for 1 of 2 residents reviewed (resident #1). The findings include: A review of the medical record for resident #1 revealed that she was a resident of the facility's locked Memory Care Unit since . Her Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823, dated stated that she required supervision in all activities of daily living (ADLs). A progress note dated signed by the Resident Care Director (RCD) stated resident #1 was observed on ground in courtyard and sent to Emergency Room for evaluation. A review of the facility provided occurrence report dated . . . . . at 7:45 AM, stated the resident was observed outside in courtyard and found lying on ground. Staff Member D, a Medication Technician (MT), wrote a statement on . . . . . as part of the facility's incident report investigation. On his statement, Staff Member D, MT, explained how on the morning of , around 7:30 AM, he was made aware that resident #1 was outside on the ground by staff working at the Assisted Living	A 165		

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WOODMONT A PACIFICA SENIOR LIVING COMMUNIT	3207 NORTH MONROE STREET TALLAHASSEE, FL 32303

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A 165	Continued From page 25 side. On . . . . . at approximately 7:59 AM, an interview was conducted with the RCD concerning the incident that involved Resident #1. During the interview the RCD stated that she did not witness the incident. The RCD stated staff reportedly found resident #1 on the ground in the courtyard and she directed them to call Emergency Medical Services for evaluation. RCD stated she did not report this incident into the Agency's Incident Reporting System (AIRS) because the incident was not considered something the facility could have prevented. RCD stated Resident #1 had history of . . . and this incident was not considered a "sentinel event". On at approximately 8:53 AM, an interview was conducted with Staff Member D, MT. During the interview Staff Member D indicated he was assigned to the Memory Care Unit on . . . . . on the first shift (6:00 AM to 2:00 PM) and thought the resident was in her room. Staff Member D, MT, indicated he was unaware of resident #1 whereabouts until staff working in another unit made him aware that resident #1 was outside on the ground. Staff Member D, MT, confirmed resident #1 was unsupervised in the courtyard. A review of the facility's policy titled "Incident Reports" dated . . . . stated "Adverse incident reports are completed per state regulations. An event in which facility personnel could exercise control rather than as a result of the resident's condition and results in any condition that required the transfer of the resident from the facility to a unit providing more acute care due to incident rather than the resident's condition before the incident".	A 165		

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
	AL11932659	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT A PACIFICA SENIOR LIVING COMMUNIT	3207 NORTH MONROE STREET TALLAHASSEE, FL 32303

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A 165	Continued From page 26 Class III	A 165		