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
	AL11964687	A. BUILDING: _____ B. WING _____	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SODALIS JACKSONVILLE	7620 TIMBERLIN PARK JACKSONVILLE, FL 32256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A biennial re-licensure survey was conducted at Sodalis Jacksonville Assisted Living Facility on /2022. The facility had deficiencies at the time of the survey.	A 000		
A 025 SS=G	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) Monitoring of the quantity and quality of resident diets in accordance with Rule	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 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, interviews, and record reviews, the facility failed to provide a level supervision consistent with the assessed needs of one of nine sampled residents (Resident #6) following an elopement on . The findings include: Review of the clinical record for Resident #6 revealed the Health Assessment (Agency for Health Care form 1823) dated revealed he was diagnosed with . with behavioral issues. Special Precautions needed were supervision and redirection. He was not listed as an elopement	A 025		

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A 025	Continued From page 2 risk at the time of the assessment. The resident was assessed as being independent with ambulation, eating and transfers. He required supervision with bathing, , self-care, and toileting. (Photographic evidence obtained) An evaluation form was authored by the HWD which indicated it was a 30-day review. Resident #6's attention span was documented as "poor." Page 4 indicated Resident #6 was, "frequently forgetful or and needs substantial staff assistance to orient to person, place, and/or time." He was to be "monitored closely" to ensure his safety. Page 16 indicated he but was, "easily redirected and did not attempt to off site." The HWD signed the assessment on . (Photographic evidence obtained) Nursing progress notes dated that Resident #6 liked to walk the halls of the facility and sit outside. On , the Resident was observed exiting the stairwell, reporting he was looking for the third floor, but the building was only two stories. He stated his apartment was on the third floor. On a care plan meeting was held with family due to increased concerns with the resident's increased and . They discussed memory care (MC), but the family declined to move the resident. On , Resident #6 continued to throughout the building, touching doorknobs, however not entering apartments. Care staff report he opened doors to rooms and appeared , turned, and left the area on a regular basis. The documentation stated Resident #6 did not appear exit seeking; he stated he was looking for his room. Staff provided escorts regularly.	A 025		

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A 025	Continued From page 3 During an interview with Employee D, Licensed Practical Nurse (LPN) and MC Program Director on . . . . . at 1:40 PM, she stated that Resident #6 eloped on at approximately 9:35 PM. Resident #6 lived on the assisted living side of the building, and he was able to leave the building when he wanted to. He did not sign out on and staff working at the time of the incident did not know he had left the property. He was found by the police a few blocks down the street. They brought him here to see if this was where he lived. She stated that he told the staff he was trying to get . . . . in the building and couldn't. The front door was locked at night. It is only unlocked from 8A-5P M-F. Family members had the code and could come and go at night. That was how they think [Resident #6] got out. She confirmed that he did have some . . . . . and . . . . . the building. A few months ago, the Administrator tried to get the family to agree to move him to the MC unit, but they refused. They did not think he needed it yet and wanted him to have as much freedom as possible. The Administrator had the family sign a Negotiated Risk Agreement (NRA) at that time. She produced the NRA dated between the resident and the facility. It read: The purpose of this Negotiated Risk Agreement is to describe Resident's choice with respect to the following: Safety Concerns. . . . . ,, which the parties acknowledge is a valid exercise of his resident rights. Risks: Elopement. Likely Consequences: Potential Danger. Benefits: Safety of [Resident #6]. The form was signed by Resident #6's daughter/Power of Attorney (POA). Alternatives offered and/or attempted to decrease risk, including but not limited to: Memory Care, pictures on door and familiar door wreaths with colors provided by family. Attempted:	A 025		

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A 025	Continued From page 4 Redirection, reminders, and cueing. The NRA conference was attended by the former Administrator, Health and Wellness Director (HWD), the Resident's POA, and her brother-in-law. (Photographic evidence obtained) Review of the facility incident report dated revealed Employee C filled out the report in her own handwritten statements. It read: Date of incident: at 11:25 PM. Resident #6 was found by Jacksonville Sheriff' Office (JSO) officer outside of facility laying on the ground about a . . . and half from the facility saying he's looking for his daughter. He was taken to the hospital with no injuries. JSO Officer says he was very . Mental status: . . . . . Condition prior to incident: /disoriented. Type of incident: Elopement. Unsafe location. Employee C wrote: "[Resident #6] seem fine at the time he did mention he was leaving to go to New York." Interventions listed included making sure doors were locked and alarmed. The form was signed by Employee C on , and by the HWD and the Administrator on . . . . . (Photographic evidence obtained). A second form titled, "General/Professional Liability Incident Report" authored by the Administrator on indicated Resident #6's care plan was currently under review, and he was reeducated on signing in and out of the building when leaving. (Photographic evidence obtained) During an interview with Resident #6 on . . . . . at 9:35 AM, he stated, "I want my freedom. I want to see my granddaughter and my daughter." He thought he has lived here a week to 10 days. He stated he left on	A 025		

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A 025	Continued From page 5	A 025		

because he wanted to see his daughter. He wanted to "find a bus". He couldn't remember where she lived. He remembered being found by the police and that he was lying on the ground. He could not explain why he was lying on the ground. He stated he could not tell the police where he lived. He remembered going to the hospital. He confirmed he had not been injured.

When asked if he ever sat in the courtyard, he stated, "Yes, I have walked around out there and I have tried to find my way into the woods. I feel safe here, but I just want to go to the Bronx because I know where the butcher shop is. I know where the produce stand is. I don't know where anything is here." He stated "I've told them I want to leave. So far, no one has helped me."

During an interview with the HWD on at 9:28 AM, she confirmed the details of Resident #6's elopement on . The Administrator was communicating with the family about the possible need to move him to the MC unit. She believed that Resident #6 needed to be on the MC unit, but she couldn't move him without the diagnosis of . She stated she contacted the resident's PCP multiple times since the elopement is waiting to hear from her.

Review of the electronic mail (e-mail) dated revealed the Administrator wrote to Resident #6's daughter/POA to inform her that the facility would like to have him re-evaluated by his physician since he eloped on and appeared very even though he had no diagnosis of . The Administrator stated that possible placement in the MC unit needed to be considered. (Photographic evidence obtained)

Review of the e-mail dated revealed

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A 025	Continued From page 6 the POA responded to the e-mail from the Administrator and expressed concern that the doors of the facility were not always locked and that was the reason she decided to place her father at this facility. She agreed her father does get . She was concerned that the front door was not monitored by staff in the evenings in case her father wanted to take an evening stroll. She had concerns about the delay in closing the front door when it was opened. She had noticed the sign on the front door the next morning after her father eloped. She asked if the Administrator thought her father's level of care needed to be changed and if she would get to her with information about each level of care. (Photographic evidence obtained) During an interview with the Administrative Assistant on at 11:45 AM, she stated that the front door was unlocked between the hours of 8A-5P M-F and locked at other times, including weekends. She sat at the front desk during those hours and was responsible for unlocking and locking the door. She had a key for the fire alarm boxes, which were to be keyed to the "ON" position when the door was locked. She confirmed that the front door did not always close all the way and needed to be pushed shut from the outside or pulled shut from the inside. That was the reason for the sign on the front door. The sign on the outside of the door read: ATTENTION When entering and leaving please make sure the door is all the way closed!!! Thanks Management. Another sign read: ATTENTION From 8AM-5PM Front door will be unlocked Mon-Fri (Photographic evidence obtained) Resident #6 was observed eating lunch in the main dining room on at 12:15 PM. He	A 025		

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A 025	Continued From page 7 was not escorted by staff to the dining room or from the dining room. He was not supervised by staff. The gate to the courtyard was unlatched and open during an observation on at 12:46 PM. Immediately behind the courtyard fencing a large densely wooded area was observed. The wooded area was not fenced off from the parking lot or sidewalk of the facility (Photographic evidence obtained.) At 12:50 PM on . . . . . , the HWD confirmed the front door was not latching and was ajar by one inch. Light could be seen coming through the opening. The fire alarm box was not connecting and was not engaged. (Photographic evidence obtained). At 12:57 PM an unidentified visitor was observed exiting the building through the front door. She did not make sure the door closed properly after she exited and kept walking toward her car. The door did not close properly. During an interview with the Regional Maintenance Director on . . . . . at 1:40 PM he explained fire alarm box on the front door had been there since [Former Owner] owned the building. It required a key to turn it on and off. If the door was opened and the box was keyed to the "on" position, the alarm should sound. It should keep sounding until it was keyed off. He stated that the alarm had to have been keyed "off" when Resident #6 left the building on at 9:30 PM, or it would have been " . . piercing." During a telephone interview on . . . . . at 3:17 PM with the Resident #6's POA, son-in-law, and second daughter, the POA stated that the JSO telephoned her at 11:05 PM the night of the	A 025		

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A 025	Continued From page 8	A 025		

elopement. She and her brother-in-law were informed by the Administrator that another family was leaving the building and entered the code. The door did close right away. It had a 4 second delay. When she questioned her father about the elopement, he had no recollection of what happened. He told her brother-in-law that he wanted to, "go for a walk". Her brother-in-law stated, "He likes to rearrange his story a lot". He explained the purpose of moving him into an assisted living facility was because Resident #6 had and needed more help and cues as reminders. Resident #6's daughter stated he wanted to go to go New York where he grew up. Regarding the NRA, the facility said Resident #6 was into other people's rooms and the hallways because he couldn't find his room. On previous visits, the front door was always locked. They wanted him there because the doors were always locked on the assisted living side. They were aware that the gate was broken at the time he moved in, but they thought they fixed it right away.

During an interview with Employee H on at 5:15, she stated she is a caregiver at this facility and has worked here for almost a year. She worked with Resident #6 since he moved in . He does not remember where his room is and he the building. She thinks he is exit seeking and needs to be on the " unit". She is aware that he eloped, and she did receive the training on elopement after it happened. She confirmed that she does not supervise him any more than she did before. "We don't have time for that."

During an interview with Employee C on at 5:30 PM she confirmed she was working the night Resident #6 eloped. She does

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A 025	Continued From page 9 not think he knows or understands that he needs to sign out. She gave him his medications on [redacted] at approximately 8:10 PM. He went to his room and shut the door. Later, she observed him open the door to his apartment and look up and down the hallway and then shut the door again. She did not know why he did that and had not seen him do that before. During the medication pass he told her that he was leaving soon to go to New York/Bronx. She told him that she did not know that. He told her he was going with his daughter. She stated she wished him luck and then he went to his room. She continued to describe Resident #6's [redacted] behavior. She thinks he is looking for a way to get out of the building. She does not understand why he has not been moved to the MC unit yet. She asked him how he left the building on [redacted], and he told her that he walked up to the front door, and it was open, so he walked out. She confirmed that the front door does not close completely unless it is pulled shut from the inside or pushed shut from the outside to engage the alarm system. She stated the receptionist is to lock and alarm the front door at 5 PM before she leaves. She stated that one time recently she was working on the MC unit and all sudden she turned around and Resident #6 was standing there behind her, which surprised her because he wasn't supposed to have the code to enter the unit. She assumed he had to have come down the stairwell at the [redacted] of the MC unit from the second story of the assisted living unit (where his room was) since he was free to walk around that floor. She stated that he needed more supervision, and she is busy with the other residents and cannot watch him. He liked to sit in	A 025		

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A 025	Continued From page 10 the front lobby and watch television. She tried to check the lobby periodically but cannot always get up there. She stated she filled out an incident report the night of the elopement. During an interview with the HWD and the MC Program Director on . . . . . at 9:45 AM, they were asked to observe the stairwell on the MC unit. The door from the MC unit into the stairwell required a key to open. The door was not alarmed. At the top of the stairwell, the door to the assisted living side is open but when opened an alarm sounded if the fire alarm box was keyed on. At the bottom of the stairwell was another door that led outside to the fenced in courtyard for MC. The door to the MC unit to the courtyard required a code. Both staff members confirmed that the only way Resident #6 could have gotten access to the MC unit would have been to come down this stairwell from the second story of the building. They both agreed that if the fire alarm box was not keyed on, no alarms would have sounded. They confirmed that the direct care staff had a key to the fire box and were responsible for making sure the box was keyed to the on position. Housekeeping staff had a key to the door leading from the MC unit into the stairwell and often left their cart underneath the stairwell there. The MC Program Director suggested that perhaps one of the housekeeping staff left the door unlocked. On . . . . . at 10:20 AM, the fire alarm box was ringing on the door from the main dining room out to the courtyard on the assisted living side. A male staff member stated that a resident went out the door and the alarm was keyed on. The Administrative Assistant came with the key and shut it off. She stated that they can leave the alarm off during the day because residents can	A 025		

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A 025	Continued From page 11 go out into the courtyard during the day. During an interview with the HWD on . . . at 12:45 PM, she stated that at the time of his admission, there was no evidence that he or had . The family did not want him to be housed on the MC unit. They were satisfied that the front door was locked all the time. After the elopement on . . . . . , the resident's family still did not want to move him to the MC unit. She stated that she and the Administrator believed he needed to be on the MC unit for his own safety. She stated that every time she talked with the daughter about moving her father, the first thing she wanted to talk about is the increased cost. She stated she was aware that the front door did not close properly unless the one using it is conscientious enough to ensure it is closed and the alarm is engaged. She confirmed that is why the sign is on the front door. She thinks the maintenance director fixed it. She stated she received a fax from Resident #6's physician this afternoon and the diagnosis of , with behavioral disturbance was now part of his diagnoses list. (Photographic evidence obtained) Review of the facility policy and procedure entitled Elopement Management mandated the facility, "Document what occurred and develop a plan to prevent the accident from occurring in the future." (Photographic evidence obtained) Class II	A 025		