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
	AL11965400	A. BUILDING: _____ B. WING _____	02/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE COUNTRYSIDE	3141 NORTH MCMULLEN BOOTH ROAD CLEARWATER, FL 33761

(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 complaint (complaint number 202300327) survey with a generator monitoring survey and a revisit to the complaint (complaint numbers 2022014777 & 2022018069) survey of was conducted at Wickshire Countryside on . The facility had deficiencies at the time of survey.	A 000		
A 025 SS=D	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,	A 025		

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A 025	Continued From page 1 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 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 record review and interview, the facility failed to maintain general whereabouts of all residents in the locked memory care unit in which one (Resident #2) of one residents eloped from the facility. Findings included: A record review was conducted on of the facility staffing schedule for the week of	A 025		

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A 025	Continued From page 2 through revealed one staff, Staff C as the only staff working from 11p.m. on to 7a.m. on (photographic evidence obtained). A record review was conducted on of Resident #2's chart revealed Resident #2 had eloped from the locked memory care unit on at 12:55a.m and returned to the facility on at 2:30a.m. by the County Sheriff Deputy. An interview was conducted on at 10:31a.m. with Staff C, she stated she was the only staff working in the memory care unit starting on at 11p.m. until at 7a.m in which resided 14 residents. She further stated that she had heard the door alarm and saw a resident by the door and just assumed that that resident had set off the alarm. Staff C stated she had no idea that Resident #2 had eloped from the facility. Class III	A 025		
A 032 SS=D	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	A 032		

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A 032	Continued From page 3 mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the 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,	A 032		

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A 032	Continued From page 4 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on interview, observation and record review the facility failed to ensure that all direct care staff have participated in elopement drills for three (Memory Care Director, Staff A and Staff D) of four employee files sampled. Additionally, the facility failed to ensure that at risk elopement residents had identification on their person for one (Resident#2) of one resident sampled. Findings included: A review of the staff attendance log of elopement drills conducted on , and did not have an entry for the Memory Care Director with a date of hire (DOH) of . A review of the staff attendance log of elopement drills conducted on , , , , and did not have an entry for Staff A with a DOH of	A 032		

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A 032	Continued From page 5 A review of the staff attendance log of elopement drills conducted on , and did not have an entry for Staff C with a DOH of . An interview was conducted with the Memory Care Director on at 9:31a.m., she stated she had not participated in any elopement drills. An interview was conducted with Staff C on at 10:21a.m., she stated she had not participated in any elopement drills. An interview was conducted on at 2p.m. with the Administrator and she agreed that all of the direct care staff had not participated in elopement drills. A review of Resident #2 chart was conducted on which revealed he had eloped from the locked memory care unit on around 1:55a.m. and was returned to the facility on at 2:30a.m. and that Resident #2 is an elopement risk. An observation was made of Resident #2 on at 9:29a.m. and revealed Resident #2 did not have identification on their person to include their name and the facility's name, address, and telephone number. An interview was conducted with the Memory Care Director on at 9:31a.m., and she stated that Resident #2 did not have any identification on their person.	A 032		

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A 032	Continued From page 6 An interview was conducted with Staff D on at 9:40a.m., and she stated that Resident #2 did not have any identification on their person. Class III	A 032		