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
	AL11965026	A. BUILDING: _____ B. WING _____	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE FORT MYERS CYPRESS LAKE	7460 LAKE BREEZE DRIVE FORT MYERS, FL 33919

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A 000	Initial Comments An unannounced complaint survey for complaint 2024006611 was conducted on [redacted] at Brookdale Fort Myers Cypress Lake, an assisted living facility, in Fort Myers, FL. Complaint #2024000661 was substantiated at 0025 Class I, 0032 Class I, 0077 Class II. The following is a description of the deficiencies.	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.	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 (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 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, resident and staff interview, the facility failed to properly supervise 1 (Resident #1) by not responding to an emergency pendant call in a timely manner. Failure to respond to an emergency pendant call resulted in the of Resident #1 on . Resident #1's pendant began pinging on at 11:18 a.m., and continued pinging until at 8:30 p.m., when Resident #1 was found in the facility's courtyard. The temperature record of the	A 025		

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A 025	Continued From page 2 day of the event was 91 F. The findings included: Requested and obtained policy name: Resident Call System and Door Alarm Response- SE-14. Effective Date: . . . . Last revised: , , . Policy overview: Associates should respond to resident call system alerts and door alarms in a reasonable and timely manner. Policy detail: B. Responding to resident call system alerts: a. When an associate receives a resident call system alert, he or she should respond in a timely manner. b. If the associate is unable to respond in a timely manner, he or she should request assistance from another associate. e. Verify the whereabouts of all residents in the community, using a current resident roster as a guide. f. Investigating alternative explanations of resident's absence (e.g. sign in -out log, , , book, bus/van driver, leave of absence, family visitation, resident program attendance, resident outings forms, etc.) g. If the resident (s) cannot be located, initiate the procedure described in the Missing Resident Policy. Initiate the Missing Resident Response Worksheet and follow the procedures described within the form. E. Resident Call systems and doors should be installed and maintained according to manufactured guidelines. F. Maintenance and testing of resident call systems:	A 025		

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A 025	Continued From page 3 a. Routinely check the equipment (pendants, call station buttons, pull , or intercoms) to determine if they are functioning properly. b. Test the call system signaling equipment monthly. d. Communicate equipment failures to the Health and Wellness Director (HWD), Executive director (ED), and Divisional Director of Property Management. e. Repair or request replacement of the equipment as soon as possible. In the event of a resident's call system failure a inform the ED, maintenance technician, regional maintenance technician, HWD and district director of operations (DDO) as soon as possible, c. ED/ designee will initiate a resident count to verify presence of all residents. d. If a resident is unable to be located, follow the missing resident policy and Missing Resident Response worksheet. Requested and obtained policy name: Missing resident policy. Effective date: . Last revised: , , , 1/202, . Policy overview: A missing resident requires immediate associate attention. If associates discover a resident's whereabouts are unknown associates must immediately begin to follow the procedures of this Missing Resident Policy. A visual (to) observation of the missing resident is considered confirmation that the resident has been found. Definitions of elopement. Assisted living facility: Any incident where a resident leaves the interior of the assisted living portion of the community, unescorted or	A 025		

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A 025	Continued From page 4 unsupervised, with or without injury, when it was previously been determined that he/she needs supervision. Policy detail: Follow the steps below until the resident is found. 1. Check the Sign in/ Sign -Out book. 2. Conduct thorough interior search of the community, but not limited to all resident rooms, common areas, closets., stairwells, offices, and rest rooms. Consider even small spaces such under beds and behind furniture. 5. Conduct a thorough exterior search of the immediate grounds. Again, consider small "hiding" spaces such as behind bushes, culverts, etc. Requested and received pendant user manual titled: Heritage Medcall Sentry Freedom R- Call System. Page 3 of the manual: Be careful following the steps in the installation manual you will be providing residents with a reliable advanced wireless emergency. Page 9. A program should be put into place, so all devices are tested semi-annually. Page 10. Location and identity When a resident uses their pendant to place an alarm, the system can provide the resident name and room number. Resident check-in. Each day the system can monitor the resident for activity. This can be an active function where the resident presses a button to check -in each day or can be a passive system that uses a motion detector or door switch to monitor resident activity. At the end of the check-in period the system will generate a report that any residents that failed to check in. The system has the capacity to have separate check-in periods each day. This helps your staff	A 025		

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A 025	Continued From page 5 provide the ultimate in supervision for the residents' well-being. Page 14 It is very important to put together a program for testing devices and system software. Factory recommendations is to test all transmitted semi-annually. Record review showed Resident #1 was admitted to the facility on [redacted]. Original Health Assessment 1823 review completed [redacted] upon admission. Diagnosis: [redacted] dependent [redacted], iron deficiency, [redacted] sleep [redacted], myoclonic [redacted], [redacted], recurrent [redacted] ( ). Physical limitations: [redacted], hearing [redacted], wears glasses. Updated Health Assessment 1823 completed on [redacted]. Diagnosis: History on [redacted] ( ), sleep [redacted] On [redacted] at approximately 11:18 a.m., Resident #1's pendant began going off signifying an emergency. Sometime before lunch, Staff A started looking for Resident #1 and went to rooms where the pendant was pinging #135, #335, and the resident's [redacted] #[redacted]. Staff A was able to locate the residents who live in #[redacted] #[redacted]. In resident [redacted] #[redacted], she saw the housekeeper. She was not able to find	A 025		

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A 025	Continued From page 6 Resident #1 or his spouse. At 12:30 p.m., Staff A went to the sign-out book and saw that Resident #1's spouse had signed out from the building. Staff A assumed Resident #1 was out with his wife. The emergency pendant continued going off all day. Staff A did not notify management or maintenance about the missing resident or that the pendant was alarming. On at 7:15 p.m., Resident #1's spouse notified the Executive Director (ED) that her husband was missing. The elopement protocol was initiated. The facility's interior and exterior were searched. The resident was not found. On at 8:03 p.m., the ED notified the police. The police arrived at approximately 8:10 p.m. A deputy found Resident #1 at 8:30 p.m. The resident was lying down in a mulched area off the sidewalk, in the backyard of the facility property. His walker was upright on the sidewalk, facing the lake. On at 8:00 a.m., in an interview, Resident #1's spouse said on at around 10:30 a.m., the housekeeper came to do the weekly cleaning and her spouse went downstairs. She stayed up and got ready to leave the building to run some errands. Resident #'1's spouse went downstairs and signed out around 12: 25 p.m. Resident #1's spouse returned to the facility around 4:20 p.m. At , , , 5 p.m., Staff (Staff C) came to the couple's apartment. Staff C told her that her pendant was going off. Resident #1's wife pointed to her pendant which was sitting in the walker not pinging. Staff C did not ask about Resident #1's whereabouts.	A 025		

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A 025	Continued From page 7 On . . . . . at 6:45 p.m., Staff (Staff D) told Resident #1's spouse that her pendant was going off. Resident #1's spouse again pointed at her pendant which was not pinging. Staff D did not ask of Resident #1's whereabouts. Resident #1's spouse said she notified the executive director (ED) at 7:15 p.m., that her husband was missing. Resident #1's wife said Resident #1 did not always go to lunch. She said she was responsible for assisting Resident #1 with his self-administration of his medications, and has been doing it for more than 20 years. She said Resident #1 was very social and spent time with friends at the facility. Resident #1's spouse said he lit up the room with his jokes and his , . She said Resident #1was the life of the party. Resident #1's spouse said she sometimes took her husband out with her when she signed out of the facility, and she made sure both names were listed when she did. She said sometimes she would run errands without him, but she did not worry since he was with his friends. She said she was not concerned about his whereabouts until the evening when he did not come . . . to their room. It was not unusual for him to hang out with friends until the early evening. Requested video surveillance material from the courtyard area. On at 8:30 a.m., the ED said there are no cameras in the building. On . . . at 10:00 a.m., during an interview, the ED said that the staff who were assigned to Resident #1 (Staff A) did not go to check on the resident as she should. The ED said Staff A asked Staff B if she saw Resident #1. Staff B told Staff A that she saw Resident #1 in the exercise	A 025		

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A 025	Continued From page 8 room between 10:30 a.m. to 11:11 a.m. The ED said Staff A went to the entrance and looked at the sign out book and saw Resident #1's spouse signed out, and she thought that Resident #1 went out with his wife. The ED said that if both residents were going out of the facility, both names should have been listed. The ED said it was later in the day, around 7:15 p.m., when Resident #1's spouse went to him and told him her husband was missing. The ED said he immediately initiated the elopement protocol. On at 8:02 p.m., when the resident was not found, the police were called. The ED said on at around 8:30 p.m., one of the deputies found the resident. The ED said Emergency Medical Services ( ) arrived. said the resident was . . . . The ED said initially Resident #1's pendant was pinging at # , # , # . . and towards the end of the day at . . # at the opposite side of the building. The ED could not provide an explanation as to why the pendant was pinging in multiple locations. The ED said none of the staff in the facility notified him that Resident #1's pendant was going off. The ED said he did not have a walkie talkie himself so he would not have known if a pendant was going off. On . . . . at 10:30 a.m., during an interview, Staff A said Resident #1's pendant started going off at 11:18 a.m. Staff A said it was pinging in the resident's # . It was also pinging in . . . # . . . . # . . . Staff A went to all 3 rooms. Staff A was able to locate the residents from . . # . . and . . # . . . Staff A was not able to locate Resident #1. Staff A said she went to the sign-out log and saw Resident #1's spouse had signed out of the facility at 12:25 p.m. Staff A said she assumed Resident #1 left the facility with his spouse. Staff A said she did not ask the	A 025		

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A 025	Continued From page 9 receptionist if Resident #1 left with his wife. Staff A said the emergency pendant continued going off for the remainder of the day. Staff A said she did not call Resident #1's wife to verify if he was with her. Staff A said she did not notify management or maintenance to see if there is something wrong with the pendant. On .. .... at 10:37 a.m., in an interview, the receptionist confirmed that Resident #1's spouse left the building alone that day. The receptionist said that if both residents left the facility, both names would have been on the sign-out log. The receptionist confirmed that Staff A did look at the sign-out book, but did not ask her if Resident #1 was also out with his wife. Staff F said on at 12:25 p.m., that Resident #1's pendant was going off in .. . # , # , # . Since she was assigned the third floor, when Staff A called her on the walkie talkie she went to # and the resident who occupied that room was there. Staff F said the pendant continued going off for the rest of the day. Staff F said Staff A told her Resident #1's spouse was out running errands so she assumed they were together. Staff F said she did not notify management or maintenance to see if there is something wrong with the pendant. On .. .... at 12:03 p.m., the Maintenance Director said that no staff came to him to let him know Resident #'1's pendant was going off. The Maintenance Director said he worked for the facility for only a month and did not know if the previous maintenance director had any testing or audits of the pendants on record. The Maintenance Director said he just had some of his assistants check batteries as needed, but he has not completed an audit since he began	A 025		

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A 025	Continued From page 10 working for the facility. The Maintenance Director could not explain why the pendant was pinging at [illegible] # [illegible], #[illegible], #[illegible], and then at the end of the day at [illegible] # [illegible] on the opposite side of the building. The Maintenance Director said he has not completed any pendant audits since the event that took place on [illegible]. On [illegible] at 1:11 p.m., the Health and Wellness Director (HWD) said, "normally I would have had a walkie talkie, but I gave it to one of the caregivers whose battery was not working. I don't remember who. No one came and told me that the pendant at [illegible] # [illegible] was going off. I had no idea. Resident #1 and his wife were pretty much independent. He had some recent [illegible]. We put him on case load for [illegible]. He was recently hospitalized due to a [illegible] ([illegible]). He had a history of [illegible]'s. When he returned, he had an order for an [illegible]. After a follow up [illegible] with his primary care physician and [illegible], they discontinued the [illegible]. Because of the history of [illegible], they did not want him to [illegible] to [illegible]. He did not have any [illegible] episodes. He knew how to use his pendant. I personally saw him use it. He knew how to use it. He used it other times." On [illegible] at 1:14 p.m., the HWD said " I was preparing to go home, it was around 7 -7:15 p.m., when the ED informed me Resident #1 was missing. None of the staff came to me prior to that to let me know he was missing. I had no idea. No, I didn't have a walkie talkie. I don't know why no one thought to come to me. He had a recent hospitalization and was still taking [illegible]. He was declining due to his [illegible]. He did not have any [illegible] episodes. He did know how to use his pendant. He used it before."	A 025		

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A 025	Continued From page 11 On at 3:06 p.m., Staff E said when she arrived on . . . . . at around 4:30 p.m., Resident #1's pendant was going off. Staff E said she asked her coworker Staff D, and she was told that Residents #1's wife was out and she assumed he was with her. When I went to . . # only Resident #1's spouse was there. Staff D said she asked Resident #1's spouse about the pendant. Resident #1's spouse told her the pendant was not pinging. Staff E did not ask Resident #1's wife about Resident #1. Staff E said "she did not say anything so I continued with my day." Staff E verified that the pendant continued going off. Staff E said she saw Resident #1's spouse sometime after 7:00 p.m., when the ED notified them he was missing and she started looking for him. Staff E said she did not notify management or maintenance to see if there is something wrong with the pendant. On at 3:10 p.m., Staff D said when she came at work at 3:00 p.m., Resident #'1's pendant was going off. Staff D said she went to . . #. . . and no one was there. Staff D said Resident #1's spouse was out of the building when she came so she though he was with her. Staff D said the pendant continued pinging. Staff E on second shift later in the day texted her and told her Resident #1 was missing. Staff D said she did not go look for the resident because she was very busy passing medications. Staff D said she did not notify management or maintenance to see if there is something wrong with the pendant. On at 3:16 p.m., Staff E said the pendant was going off from the time she came into the facility at 3:00 p.m. Staff E said when she came to # . . . it was empty. Staff E said resident #1's spouse was out. Staff E said she did not	A 025		

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A 025	Continued From page 12 start looking for the resident. Staff E said she did not notify management or maintenance to see if there is something wrong with the pendant. Staff E said she started looking room by room after she was notified by the ED later in the evening that he was missing. Staff E did not remember the exact time. Class I	A 025		
A 032 SS=J	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of	A 032		

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	AL11965026	A. BUILDING: _____ B. WING _____	05/13/2024

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BROOKDALE FORT MYERS CYPRESS LAKE	7460 LAKE BREEZE DRIVE FORT MYERS, FL 33919

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A 032	Continued From page 13 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 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 record reviewed, and staff interview, the facility failed to conduct elopement drills according to policies and procedures. Facility's failed to ensure that elopement policy and	A 032		

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A 032	Continued From page 14 procedure included the identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, and continued care of all residents within the facility in the event of an elopement. Facility failed to ensure elopement drills conducted pursuant to Section 429.41(1)(k), F.S. Facility failed to ensure all administrators and direct care staff participated in the drills, which must include a review of the facility 's procedures to address resident elopement. Failure to conduct elopement drills per regulatory requirement resulted to Resident #1's on . Findings included: Requested and obtain policy name: Missing resident policy. Effective date: . Last revised: , , , , 1/202, , , , . Policy overview A missing resident requires immediate associate attention. If associates discover a resident's whereabouts are unknown associates must immediately begin to follow the procedures of this Missing Resident Policy. A visual (to) observation of the missing resident is considered confirmation that the resident has been found. Definitions of elopement. Assisted living facility: Any incident where a resident leaves the interior of the assisted living portion of the community, unescorted or unsupervised, with or without injury, when it was previously been determined that he/she needs supervision. Policy detail Follow the steps below until the resident is found.	A 032		

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A 032	Continued From page 15 1. Check the Sign in/ Sign -Out book. 2. Conduct thorough interior search of the community, but not limited to all resident rooms, common areas, closets., stairwells, offices, and rest rooms. Consider even small spaces such under beds and behind furniture. 5. Conduct a thorough exterior search of the immediate grounds. Again consider small "hiding" spaces such as behind bushes, culverts, etc. Requested and obtain policy name: Missing Resident Drills Policy. Effective Date: . Last revised: , , , , ,10/ 2021, , , , Policy overview: Communities shall conduct missing resident drills on a monthly basis, on rotating shifts, as directed by the Executive Director (ED)/designee. 1. the executive director (ED) is responsible for conducting or delegating the completion of monthly community missing drills. 2. Missing resident drills shall be conducted monthly with each shift participating on a rotating basis for rotating shifts on a quarterly basis or pursuant to the applicable state regulation-whichever more frequent. Facility's elopement policy and procedure review revealed that the policy did not include the identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, and continued care of all residents within the facility in the event of an elopement. Record review showed Resident #1 was admitted to the facility on .	A 032		

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A 032	Continued From page 16 Original Health Assessment 1823 review completed upon admission. Diagnosis: [illegible] dependent [illegible], iron deficiency, [illegible] sleep [illegible], moronic [illegible], [illegible], recurrent [illegible], track [illegible] (UT's). Physical limitations: [illegible], Recurrent [illegible] 's, hearing [illegible]. Wears glasses. Updated Health Assessment 1823 completed on [illegible]. Diagnosis: History on [illegible], [illegible] ([illegible]), sleep [illegible], [illegible]. On [illegible] at approximately 11:18 a.m., Resident #1's pendant began going off signifying an emergency. Sometime before lunch Staff A started looking for Resident#1 and went to rooms where the pendant was pinging #135, #335, and the Resident's [illegible] #[illegible]. Staff A was able to locate the residents who live in # # . In resident [illegible] #[illegible], she saw the housekeeper. She was not able to find Resident #1 or spouse. At 12:30 p.m., staff A went to the sign-out book and saw that Resident #1's spouse had signed out from the building. Staff A assumed Resident#1 was out with his wife. The emergency pendant continued going off all day. Staff A did not notify management or maintenance about the missing resident or the pendant alarming. On [illegible] at 7:15 p.m. Resident #1's spouse notified the executive director (ED) that her	A 032		

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A 032	Continued From page 17 husband was missing. The elopement protocol was initiated. The facility's interior and exterior were searched. Resident #1 was not found. On at 8:03 p.m. the ED notified the police. The police arrived at approximately 8:10 p.m. A deputy found Resident #1 at 8:30 p.m. Resident #1 was lying down in a mulched area off the sidewalk, in the backyard of the facility property. His walker was intact. Requested video surveillance material from the courtyard area. On at 8:30 a.m. the ED said there are no cameras in the building. Requested and obtain facility elopement drills. 11:00 a.m. A total of 6 staff participated in the drill. 11:00 p.m. A total of 2 staff participated in the drill. no time provided. A total of 8 staff predicated in the drill. am (no time provided). 5 staff participated in the elopement drill. . No time provided. A total of 6 staff provided. (no year provided) 9:30 (no specific A.M. or P.M. provided). A total of 8 staff participated. at 7:13 (not morning or evening information provided). A total of 5 staff participated. 10:00 a.m. total of 5 staff participated. no time provided. A total of 5 staff participated. no time provided. A total of 6 staff participated. no time provided. A total of 5 staff participated. /(not year or time provided). A total of 7 staff participated.	A 032		

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A 032	Continued From page 18 Administrator said on at 10:20 a.m. there was no system in place to ensure all staff participated in elopements drills as required. Administrator said only staff in the memory unit participated in monthly elopement drills. Administrator said the memory unit director was responsible to complete the monthly elopement drills. Administrator said he has not participated in an elopement drill since he was hired about four months ago. On at 10:30 a.m., during an interview, Staff A said she has being working for the facility little over a year and she did not participate in any elopement drills. On at 10:37 a.m. in an interview, the receptionist said she did not participate in any elopement drills. Staff F said on at 12:25 p.m. that has been working at that building for about 21 years. Staff F said the previous owners used to conduct elopement drills regularly. Staff F said since the new owner took over more than 10 years she did not recall participating in an elopement drill . Health Wellness Director on at 1:11 p.m. said she did not participate in any elopement drills. Health Wellness coordinator on at 1:14 p.m. said she did not participate in any elopement drills. On at 3:06 p.m., Staff C said she did not participate in an elopement drill. On at 3:10 p.m., Staff D said she did not	A 032		

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A 032	Continued From page 19 participate in an elopement drill. On . . . . at 3:16 p.m., Staff E said she did not participate in an elopement drill. In a follow up interview with the ED on at 3:40 p.m., the ED confirmed that elopement drills were conducted only in the memory unit. ED confirmed only staff that worked in the memory unit participated in the elopement drills. ED acknowledged they did not have a system in place to ensure all staff participated in elopement drills as required. ED confirmed there was no recent elopement drill after the incident that took place on . . . . . . ED said he was waiting for all the in services training's to be completed before he initiated an elopement drill. Class I	A 032		
A 077 SS=G	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52	A 077		

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A 077	Continued From page 20 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and,	A 077		

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A 077	Continued From page 21 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the . . . . of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile . . . . of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to	A 077		

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A 077	Continued From page 22 paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No =Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility's administrator failed to provide appropriate care to residents as required for 1 resident (#1) out of 1 resident reviewed. Failure to provide proper care resulted in Resident #1's on . Resident #1's pendant began pinging on at 11:18 a.m., and continued pinging until at 8:30 p.m., when Resident #1 was found in the facility's courtyard. The temperature record of the day of the event was 91 F. The findings included: Requested and obtained Job description titled Executive Director III. Signed . Under essential functions:	A 077		

Agency for Health Care Administration

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A 077	Continued From page 23 1. Responsible for all operations within the community, interacting with staff and residents, prospects, or their families, as necessary. 10. Works with maintenance and other appropriative department leaders to ensure building, grounds, and property are up to company standards, engages in active oversight of preventative maintenance systems and programs and frequent inspections that meet company standards of . . . . . . 11. Enforces current company policies and procedures. Requested and received pendant user manual titled: Heritage Medcall Sentry Freedom R- Call System. Page 3 of the manual: Be careful following the steps in the installation manual you will be providing residents with a reliable advanced wireless emergency. Page 9. A program should be put into place, so all devices are tested semi-annually. Page 10. Location and identity. When a resident uses their pendant to place an alarm, the system can provide the resident name and room number. Resident check-in. Each day the system can monitor the resident for activity. This can be an active function where the resident presses a button to check -in each day or can be a passive system that uses a motion detector or door switch to monitor resident activity. At the end of the check-in period the system will generate a report of any residents that failed to check in. The system has the capacity to have two separate check in periods each day. This helps your staff provide the ultimate supervision for the residents' wellbeing. Page 14. It is very important to put together a	A 077		

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A 077	Continued From page 24 program for testing devices and system software. Factory recommendations is to test all transmitted semi-annually. Requested and obtain policy name: Missing resident policy. Effective date: . . . . Last revised: , , , 1/202, ... , ... , ... , ... Policy overview A missing resident requires immediate associate attention. If associates discover a resident's whereabouts are unknown associates must immediately begin to follow the procedures of this Missing Resident Policy. A visual (to) observation of the missing resident is considered confirmation that the resident has been found. Definitions of elopement. Assisted living facility: Any incident where a resident leaves the interior of the assisted living portion of the community, unescorted or unsupervised, with or without injury, when it was previously been determined that he/she needs supervision. Policy detail Follow the steps below until the resident is found. 1. Check the Sign in/Sign -Out book. 2. Conduct thorough interior search of the community, but not limited to all resident rooms, common areas, closets., stairwells, offices, and rest rooms. Consider even small spaces such under beds and behind furniture. 5. Conduct a thorough exterior search of the immediate grounds. Again, consider small "hiding" spaces such as behind bushes, culverts, etc.	A 077		

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A 077	Continued From page 25 Requested and obtained policy name: Missing Resident Drills Policy. Effective Date: . Last revised: ,10/ 2021, , , . Policy overview: Communities shall conduct missing resident drills on a monthly basis, on rotating shifts, as directed by the Executive Director (ED)/designee. 1. the executive director (ED) is responsible for conducting or delegating the completion of monthly community missing drills. 2. Missing resident drills shall be conducted monthly with each shift participating on a rotating basis for rotating shifts on a quarterly basis or pursuant to the applicable state regulation-whichever is more frequent. Record review showed Resident #1 was admitted to the facility on . Original Health Assessment 1823 review completed upon admission. Diagnosis: (a wire mesh tube that keeps an , propped open to increase flow to the), , dependent , iron deficiency, , sleep , myoclonic , , recurrent ('s). Physical limitations: , Recurrent 's, hearing , . Wears glasses. Updated Health Assessment 1823 completed on . Diagnosis: History on , , , , ( ), sleep ,	A 077		

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(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 077	Continued From page 26 On at approximately 11:18 a.m., Resident #1's pendant began going off signifying an emergency. Sometime before lunch Staff A started looking for Resident#1 and went to rooms where the pendant was pinging #135, #335, and Resident #1's #. Staff A was able to locate the residents who live in #, #, #. In Resident #1's #, she saw the housekeeper. She was not able to find Resident #1 or his spouse. At 12:30 p.m., Staff A went to the sign-out book and saw that Resident #1's spouse had signed out from the building. Staff A assumed Resident #1 was out with his wife. The emergency pendant continued going off all day. Staff A did not notify management or maintenance about the missing resident or that the pendant was alarming. On at 7:15 p.m., Resident #1's spouse notified the executive director (ED) that her husband was missing. The elopement protocol was initiated. The facility's interior and exterior were searched. Resident #1 was not found. On at 8:03 p.m., the ED notified the police. The police arrived at approximately 8:10 p.m. A deputy found Resident #1 at 8:30 p.m. Resident #1 was lying down in a mulched area off the sidewalk, in the backyard of the facility property. His walker was upright on the sidewalk, facing the lake. On at 8:00 a.m., in an interview, Resident #1's spouse said on at around 10:30 a.m., the housekeeper came to do the weekly cleaning and her spouse went downstairs. She stayed up	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965026	A. BUILDING: _____ B. WING _____	05/13/2024

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A 077	Continued From page 27 and got ready to leave the building to run some errands. Resident #'1's spouse went downstairs and signed out around 12: 25 p.m. Resident #1's spouse returned to the facility around 4:20 p.m. At around 5 p.m., Staff (Staff C) came to the couple's apartment. Staff C told her that her pendant was going off. Resident #1's wife pointed to her pendant which was sitting in the walker not pinging. Staff C did not ask about Resident #1's whereabouts. On . . . . . at 6:45 p.m., Staff (Staff D) told Resident #1's spouse that her pendant was going off. Resident #1's spouse again pointed at her pendant which was not pinging. Staff D did not ask of Resident #1's whereabouts. Resident #1's spouse said she notified the executive director (ED) at 7:15 p.m., that her husband was missing. Requested video surveillance material from the courtyard area. On . . . . . at 8:30 a.m., the ED said there is no video surveillance in the building. On at 10:00 a.m., during an interview, the Executive Director (ED) said that the staff assigned to Resident #1 (Staff A) did not go to check on the resident as she should. Per ED Staff A asked Staff B if she saw Resident #1. Staff B told Staff A that she saw Resident #1 in the exercise room between 10:30 a.m. to 11:11 a.m. The ED said Staff A went to the entrance and look at the sign out book and saw Resident #1's spouse signed out and she though that resident #1 went out with his wife. The ED said that if both residents were to be going out of the facility, both names should have been listed. The ED said it was later in the day around 7:15 p.m. when Resident #1's spouse went to him and told him	A 077		

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A 077	Continued From page 28 her husband was missing. ED said he immediately initiated elopement protocol. When Resident#1 was not found, police were called on at 8:02 p.m. ED said one off the deputies found Resident #1 on at around 8:30 p.m. The ED said Emergency Medical Services ( ) arrived. said the resident was . The ED said initially Resident #1's pendant was pinging at # ,# ,# and towards the end of the day at # at the opposite side of the building. The ED could not provide an explanation of why the pendant was pinging in multiple locations. The ED said none of the staff in the facility notified him that Resident #1's pendant was going off. The ED said he did not have a walkie talkie himself so he would not have known if a pendant was going off. Resident #1's pendant continued pinging from at 11:18 a.m., up to the time resident found at the facility's courtyard on at approximately 8:30 p.m. On at 12:03 p.m., the Maintenance Director said no staff came to him to let him know Resident #'1's pendant was going off. The Maintenance Director said he worked for the facility for only a month and did not know if the previous Maintenance Director had any testing or audits of the pendants on record. The Maintenance Director said he just had some of his assistants check batteries as needed, but he did not complete an audit since he began working for the facility. The Maintenance Director could not explain why the pendant was pinging at # , # , # and then at the end of the day at # , which is on the opposite side of the building. The Maintenance Director said he has not completed any pendant audits since the event that took place on . The Maintenance	A 077		

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A 077	Continued From page 29 Director said they called the pendant company, and they have an , , for them to come and check the system on . . . . . . On at 4:40 p.m., the ED confirmed that no audits of the pendant system took place since the event on . The ED could not provide evidence of any previous pendant audits. The ED confirmed Resident #1's pendant continued pinging from . . . . . at 11:18 a.m. up to the time resident found at the facility courtyard on . . . . . at proximately 8:30 p.m. The ED confirmed that they have a set , , on . . . . . for the pendant company to come out and check the system. ED confirmed that elopement drills are only conducted in the memory unit. The ED confirmed that only staff who worked in the memory unit participated in the elopement drills. The ED acknowledged they did not have a system in place to ensure all staff participated in elopement drills as required. The ED confirmed there was no recent elopement drill after the incident that took place on . The ED said he was waiting for all the inservice training's to be completed before he initiated an elopement drill. Class II .	A 077		