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
	AL11965374	A. BUILDING: _____ B. WING _____	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELITE ALF AT NAPLES LLC	1155 ENCORE WAY NAPLES, FL 34110

(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 relicensure limited nursing services, emergency power plan monitoring, health facility reporting system, generator, visitation form, and complaint survey for #2023016854, #2023017002, #2024002423, and #2023010309 was conducted on through at The Elite ALF at Naples, an assisted living facility, in Naples FL. Complaint #2023016854 was unsubstantiated. Complaint#2023017002 was substantiated. Complaint #2024002423 was unsubstantiated. Complaint #20230101309 was unsubstantiated. The following is a description of the deficiencies.	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	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 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 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 staff interview, the	A 025		

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A 025	Continued From page 2 facility failed to provide proper supervision to 1 (Resident #12) of 2 residents reviewed. The facility failed to provide care and services according to residents needs accepted for admission to the facility for 1 (Resident #12) out of 1 resident reviewed. Findings included: Requested and obtained policy titled Elopement and Missing Resident Plan. Effective date: . . . Procedure: . . . 3. Residents are assessed upon move-in, quarterly, and change of condition for elopement using the Elopement Risk Tool. 4. Residents who are assessed as an elopement risk: . . . Will have 15-to-30-minute checks depending on risk, Private duty caregiver may be required until adjustment to community is made. Record review revealed Resident #12 was admitted on . The original Health Assessment Form 1823 in place dated included diagnoses of , , Major , previous issues with memory, tinnitus, , , , , , has memory issues. Documented as as elopement risk. Elopement risk assessment review for Resident #12 showed Resident #12 was assessed on and the outcome was 11 (high risk). A second elopement risk assessment on record was completed after the second elopement, on . Result was 11 points (high risk). Incident record review for Resident #12 said that on at around 7:00 a.m. staff noticed that	A 025		

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A 025	Continued From page 3 Resident #12 was not on premises. Staff immediately initiated the elopement protocol. Staff noticed a chair by the fence. Facility notified police and Resident #12 was found about a mile away from the facility. Resident #12 was sent to the hospital for evaluation. Resident #12 returned to the facility the same day. Resident #12 said she was walking towards Naples park because her ex-husband was there and he had the grandkids and wanted to see them. Record review revealed on at 8:25 a.m., Resident #12 could not be found in the building. The Elopement protocol initiated, and police were called. Resident #12 was found by the police shortly after about 2 and a half miles away from the facility. The Health and Wellness Director (HWD) noticed a bucket close to the fence and assumed that is how the resident left the facility. Interview with Medication Tech (MT) Staff B on at 8:14 a.m., she said she knew Resident #12 had a history of elopements since she used to be a resident in the facility in the past and had an elopement some time in 2021. Staff B said the resident tied sheets to a rope and jumped out of the fence. Staff B said as result of that elopement Resident #12 was discharged. Staff B said the Resident #12 was readmitted again in . Staff B said no special instructions were given to her or the other staff in order to prevent future elopements. Staff B said Resident #12 was very smart and knew how to leave. Staff B said no one came to her or other staff and told her to "keep an " on the resident. Just the normal rounds. Interview with MT Staff C on at 10:15 a.m., Staff C verified that Resident #12 was in the facility before and was discharged due an	A 025		

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A 025	Continued From page 4 elopement in the past. Staff C said she was aware of Resident #12's prior elopement history, but no special instructions were given to her or other staff to prevent future elopements. Interview with Caregiver (CG) Staff A on at 10:20 a.m., Staff A verified that Resident #12 was in the facility before and was discharged due an elopement in the past. Staff A said she was aware of Resident #12's prior elopement history, but no special instructions were given to her or other staff to prevent future elopements. During an interview with the HWD on at 11:38 a.m., she said she was in her office when the elopement took place. HWD said she found a bucket by the door. HWD said Resident #12 most probably used the bucket to jump and leave. Resident #12 was sitting outside as usual. When they realized she was missing they started looking for her. The HWD said they did not have any special interventions after the first elopement. Just the two-hour checks and the new doorbell. During an interview with the Regional Executive Director (RED) on at 12:24 p.m., she said she was not here when it happened but when someone is deemed as an elopement risk they were suppose to check on them every two hours. She was not aware of any other interventions. The RED said the resident was able to go sit outside unsupervised. They were suppose to check on the resident every two hours same as every other resident, but they did not have a check list. We added an additional staff at every shift. The RED verified that Resident #12 had an elopement in 2021 when she tied the sheets to a rope and left the premises. The RED said the state cited the facility for that elopement and eventually Resident #12 was discharged. The	A 025		

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A 025	Continued From page 5 RED said that the previous Executive Director (ED) accepted Resident #12 in . . . . Per the RED the previous ED said the resident's daughter begged the previous ED to take her . . . because no facility wanted her. The previous ED felt sorry for Resident #12's daughter. The previous ED did not have any discussions with the family about private duty or putting interventions in place even though she was aware of Resident #12's prior elopement history. During an interview with the RED on . . . . at 3:30 p.m., she confirmed that there were no interventions in place upon admission even though Resident #12 was deemed as an elopement risk. The RED confirmed that staff were not instructed to check Resident #12 every 15-30 minutes. Class II .	A 025		
A 032 SS=G	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A	A 032		

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A 032	Continued From page 6 resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case	A 032		

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A 032	Continued From page 7 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 review, and staff interview, the facility failed to conduct elopement drills according to regulations. The facility failed to ensure elopement drills were conducted pursuant to Section 429.41(1)(k), F.S. The facility failed to ensure all administrators and direct care staff participated in 2 drills annually, which must include a review of the facility's procedures to address resident elopement. Failure to conduct elopement drills per regulatory requirements directly effects staff response and led to Resident #12's elopements on and . Findings included: Requested and obtained policy titled Elopement and Missing Resident Plan. Effective date: Procedure: . . . 3. Residents are assessed upon move-in, quarterly, and change of condition for elopement using the Elopement Risk Tool. 4. Residents who are assessed as an elopement risk: . . . Will have 15-to-30-minute checks depending on risk, Private duty caregiver may be required until adjustment to community is made. . . . 7. Missing resident drills will be done twice yearly for associates. 8. All associates will be provided with a copy of the community's missing resident polices and	A 032		

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A 032	Continued From page 8 procedures. 9. All associates will receive in-service training regarding the missing resident policies and procedures within 30 days of hire. Record review revealed Resident #12 was admitted ..... The Health Assessment Form 1823 in place, dated ..... included Diagnoses of , , Major , previous issues with memory, tinnitus, , , , , , has memory issues. Deemed as elopement risk upon admission. Incident record review for Resident #12 said that on at around 7:00 a.m., staff noticed that Resident #12 was not on premises. Staff immediately initiated elopement protocol. Staff noticed a chair by the fence. Facility notified police and Resident #12 was found about a mile away from the facility. Resident #12 was sent to the hospital for evaluation. Resident #12 returned to the facility the same day. Resident #12 said she was walking towards Naples park because her ex-husband was there and he had the grandkids and wanted to see them. Elopement assessment review for Resident #12 showed Resident #12 was assessed on ..... and the outcome was 11 (high risk). On at 8:25 a.m., Resident #12 could not be found in the building. The Elopement protocol was initiated, and police were called. Resident #12 was found by the police shortly thereafter about 2 and a half miles away from the facility. Health and Wellness Director (HWD) noticed a bucket close to the fence and assumed that is how the resident left the facility.	A 032		

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A 032	Continued From page 9 Second elopement risk assessment on record was completed after the second elopement on . . . . . Result was 11 points (high risk). Requested elopement drills. 43 direct care staff work in the facility. There was a drill on 10:45 a.m., total of 15 staff participated. Of the 43 current direct care staff who were hired before , 16 did not participate in the drill. Elopement drill on at 11:15 a.m., A total of 13 staff participated. Elopement drill on at 11:30 a.m., Elopement drill. A total of 8 staff participated. Of the 43 direct care staff hired before , 33 did not participate in the drill. There was an in-service elopement training after the second elopement that was completed on . . . . , 16 out of 43 current direct care staff participated in the in-service. During an interview with the Regional Executive Director (RED) on . . . . at 3:30 p.m., she confirmed there were no interventions in place upon admission even though Resident #12 was deemed an elopement risk. The RED confirmed staff were not instructed to check Resident #12 every 15-30 minutes. The RED confirmed no additional interventions were put in place after the first elopement which took place on , other than placing the doorbell and adding one more staff. The RED confirmed there was no evidence that all staff participated in 2 elopement drills annually as required. Class II	A 032		