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
	AL11911669	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD VILLAGE RETIREMENT COMMUNITY	7830 PINE FOREST ROAD PENSACOLA, FL 32526

(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 survey for complaint numbers 2023003060, 2023003141, and 2023005849 was conducted at Homestead Village Retirement Community on [redacted]. Deficiencies were identified at the time of survey. A Class I deficiency was identified on [redacted] at N0025 Resident Care and Supervision related to staff failure to provide care, services and supervision appropriate to the needs of the residents. The survey team found that Resident #1 was able to exit the secured memory care cottage without staff knowledge which resulted in being fatally wounded by a vehicle 2 miles from the facility. Resident #51 was observed by the survey team lying on the floor of the memory care cottage while the only staff member present was making no attempts to assist them. At the time of the survey the facility's census was 84 with 46 of these residents residing in the facility's memory care cottages.	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	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 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 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	A 025		

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A 025	Continued From page 2 method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and a record review, the facility failed to provide care, services and supervision appropriate to the needs of 2 of 8 residents reviewed that resided in the Memory Care Unit (Residents #1 and #51). The survey team found that Resident #1 was able to exit the secured memory care cottage without staff knowledge which resulted in being fatally wounded by a vehicle 2 miles from the facility. Resident #51 was observed by the survey team lying on the floor of the memory care cottage while the only staff member present was making no attempts to assist them. The survey team found that all 46 residents who reside in the facility's memory care cottages were at risk due to staff not providing appropriate supervision. These failures resulted in a Class I deficiency. The findings include: RESIDENT #1 Resident #1 was found to be missing from his residence when Staff Member F, Patient Care Assistant ( ), was conducting morning rounds with Staff Member B, , on at approximately 6:00 AM. They noted that Resident #1's room was locked, at which time the Supervisor was called to come and unlock his door. When the supervisor unlocked Resident #1's door, he was not located within his	A 025		

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A 025	Continued From page 3 apartment. Staff Member F, , stated that she immediately started searching the cottage and, when she was unable to locate Resident #1, she notified the House Supervisor who initiated the Elopement Policy procedure. The House Supervisor notified Law Enforcement and the Executive Director. Staff Member B, , reported to the Supervisor and the Executive Director (ED) that Resident #1 was rounded on by her at 2:30 AM and 4:30 AM and last seen at that time in bed wearing black underwear. However, the facility's investigation determined that Staff Member B, , falsely marked seeing Resident #1 when she did not actually visually observe him during these times. A review of the facility's investigation revealed that the last verified observation of Resident #1 was on , 12:00 AM at which time he received a Norco (a , reliever) tablet for , from the Night Shift Supervisor. It was later determined by Law Enforcement that Resident #1 was involved in a hit and run accident at mile marker 8 on Interstate I-10 East at 5:00 AM and pronounced at 6:11 AM at the scene of the accident by responding emergency personnel. Further review of the facility's investigation revealed that County Sheriff's Department (ECSO) responded to the Independent Living section of the facility at 3:17 AM that morning ( ) when a female resident reported that an unknown man had entered her apartment. The unknown man had exited the apartment and was not located by the ECSO officer. It was later determined by Law enforcement that the unknown man fit the description of Resident #1. At approximately 4:00 AM, Staff Member G, , reported an unknown	A 025		

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A 025	Continued From page 4 male had attempted to enter cottage C, and at the time was thought to be a transient person. During the search for Resident #1, it was determined by the ECSO and Florida Highway Patrol that the victim of the hit and run accident on Interstate I-10 East was Resident #1. A record review was conducted for Resident #1 which revealed he was admitted to the facility on , with diagnoses of 's, no physical or sensory limitations, Alert and Oriented times 1 (to self only). He was not deemed an elopement risk, was independent for ambulation, bathing, , eating, grooming, toileting, transferring. The record revealed the resident had been involuntarily admitted to a local mental health facility pursuant to the Florida Mental Health Act of 1971 (" ") on for aggressive behavior reported by his wife. The behavior was determined to be a progression from his baseline . The was rescinded following a exam due to not meeting criteria, however, he was determined at this time to not have capacity to make any rational decisions due to . His wife signed all admission paperwork. A review of the corrective actions implemented based on the facility's investigation into the elopement and subsequent of Resident #1 included staff education on the policies for Elopement/Missing Resident and Resident Care and resident supervision, staff were to read the policies sign in and were given a copy for their reference. Review of the documentation revealed the training for all staff had not been completed prior to survey entrance on . Also included in the plan was changing the codes to open the secured doors in the Memory Care Cottages	A 025		

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A 025	Continued From page 5 (Cottages D, I, J and K). The documentation supported that the door codes were not changed until [redacted] after the assistant maintenance director contacted the service provider for instructions. On [redacted], Staff B, [redacted] was suspended pending completion of investigation, and was terminated on Monday [redacted]. On [redacted] at 1:50 PM, a telephone interview was conducted with the officer at the Florida Highway Patrol who responded to the accident, who stated that they received a call at approximately 5:00 AM of an individual lying on the side of Interstate I-10 East at mile marker 8. There was a deputy responding to the elopement at the Assisted Living Facility (ALF) that came to the scene and assisted them in identifying the body at the scene of the accident as Resident #1. The Emergency Medical Services ([redacted]) pronounced the victim [redacted] on scene when they responded at 6:11 AM. On [redacted] at approximately 3:45 PM, an interview was conducted with the Assistant Maintenance Director who stated that the delay in changing the door codes on the memory care cottages was a result of the company that made the locks not returning his call regarding how to change the codes. He reported that he had not received the instructions on how to change the locks until [redacted]. He reported that he had ordered door alarms for the memory care cottages that activate an audible alarm if the door remains open for more than 15 seconds. These were ordered on [redacted] however were not received until [redacted], at which time they were installed. On [redacted] at approximately 5:15 PM, an interview was conducted with the ED, who stated	A 025		

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A 025	Continued From page 6	A 025		

that they believe that it was a rogue employee that did not follow their policy and procedures for resident supervision and chose not to follow their protocols. The ED stated that Staff Member B, , showed no remorse during their investigation interview. The facility was unable to definitively identify the specific means that Resident #1 used to exit the facility. Staff Member B admitted to leaving the cottage unsupervised for a brief period of time while she was in her personal vehicle. The specific amount of time was undetermined. The ED stated that the resident was high functioning as evidenced by being able to use his smart phone and smart TV. The ED stated it was possible Resident #1 observed the door code, overheard the door code, or exited the door when it was left ajar by Staff Member B went to her vehicle. Staff Member B denied leaving the door ajar.

On at approximately 12:40 PM, an interview was conducted with Staff Member F, , who stated that she had worked with Resident #1 prior to the event on Friday ( ). She stated that on Thursday at shift change at around 6:00 PM, Resident #1 tried to push her out the door. She further stated that Staff Member B, , was present at that time, and she requested Staff Member B notify the supervisor that Resident #1 was trying to elope. She offered that Resident #1 would walk around the cottage and kick at the doors and state he wanted to be let out. When asked if these concerns had been reported, Staff Member F, , stated, "yes, I notified [Staff Member H, Licensed Practical Nurse (LPN)]". She further reported that, prior to the day the resident eloped, she had worked with him on Saturday, , and was informed by Staff Member H, LPN, that Resident #1 was a flight risk, when she received

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A 025	Continued From page 7 the report. She stated that staff do rounds in memory care every two hours, and the doors are locked. She went on to state that she had not received training on elopement except what was in the orientation packet. She stated she has been working at the facility since the beginning of . . . . . She stated that they have not asked her to sign the elopement training today as of yet. She went on to state she noticed the elopement books today ( ) and had been reading over it earlier, but prior to today she had not seen any elopement books. On at approximately 1:07 PM, an interview was conducted with Staff member L, a Medication Technician (MED/TECH), who stated that she had received training on elopement prior to the event on Friday. She stated they have done drills in the past; however she had not received the training in-service since then, stating she was off Saturday through Wednesday and returned to work today. On at approximately 5:48 PM, an interview was conducted with the ED and the CEO/Owner who reviewed the results of the investigation process and the corrective measures that had been put into place since the elopement of Resident #1 on . . . . . They reported that staff had been re-educated and that there had been alarms installed on the doors of the locked units. The Access doors' codes had been re-coded. On . . . . . at 7:36 PM, a telephone interview was conducted with Staff Member H, LPN, who confirmed that she was told Resident #1 was a flight risk and she relayed that information to Staff Member F on . . . . . She was not sure who had told her that he was an elopement risk, and she	A 025		

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A 025	Continued From page 8 did not contact anyone to verify. She reported that Resident #1 had periods of and wanted to go outside, but staff would sit with him on the front porch. She stated that, on , she had to go over to the cottage to help distract Resident #1 because he was kicking at the doors because "he did not want his wife to leave with their dog". Staff were able to redirect him, and he was sitting at the table in the dining room when she left the cottage. She went on to state that his wife called to check on him and voiced that she was not sure if he would try and get out, but was concerned that if he did, he would attempt to come home. On at approximately 12:54 PM, an interview was conducted with the ED, who stated that they conducted the elopement drill on but have not had time to do any more drills since then but we will get to that right away. Resident #51 On at approximately 4:10 PM, two surveyors knocked on the door of the locked Memory Care Cottage J, however, no staff responded after 10 minutes of knocking. Surveyors then went to a nearby cottage to request another staff member open the door of the Memory Care Cottage. Upon entering cottage J, surveyors observed Resident #51 lying on the floor in the common area while Staff Member J, , was sitting on the loveseat facing the resident holding his cell phone. When the staff member was asked what happened, he stated the resident had slid out of her chair and that he had slid her down his onto the floor. When asked if he had called for help, he replied, "no, because I don't not know the number to call to get help". When surveyors asked if he heard us knocking on the door, he stated he did not, but	A 025		

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A 025	Continued From page 9 that he could not have left the resident anyway. Staff were able to find and bring the Assistant Director of Nursing (ADON). The ADON evaluated the resident and instructed Staff Member J to report to the ED. Staff Member J went to exit the cottage and asked for the code to which both the ADON and Staff Member M, told Staff Member J the code out loud in front of Resident #51. After the resident was evaluated and assisted into her wheelchair, one of the surveyors went to the window and knocked, this surveyor and the ADON were both able to hear the knock without any difficulty. On at 5:48 PM, an interview was conducted with the ED and the Chief Executive Officer (CEO)/Owner of the facility, who stated that Staff Member J did not report to the ED's office as instructed by the ADON, we informed her that he was observed in the car by this surveyor leaving the facility on our way to the conference room. The ED stated she was aware of what occurred with resident #51 and was going to terminate Staff Member J. On at approximately 11:30 AM, an interview was conducted with the ADON and the ED. The ED stated she now makes the schedule for the week, and the ADON stated that herself and Nurse H, LPN, adjust the schedule, depending on call ins. They assign PCAs to the cottages, and that Nurse H had assigned Staff member J, to the Memory Care Cottage. She stated that they orient new employees with other PCAs for 2 days before being on their own. They stated that Staff Member J was oriented in another cottage that had 8 residents and was notified he was unable to maintain 8 residents so Nurse H assigned him to cottage J with 2 residents. They stated that they had been going	A 025		

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A 025	Continued From page 10 in and checking on Staff Member J throughout the day prior to the . They had noticed he had not attempted to serve the residents their lunch at lunchtime, the trays were in the kitchen area and he had to be instructed on setting the residents up for the meal. However, she did not assign another staff member to assist with Staff Member J or remove him from the cottage prior to the . On , a record review was conducted of staff member J, which revealed no per-orientation training on file. A follow up interview was conducted with the ED, who stated she had done his pre-orientation training with him and was not sure why that documentation was not in his file, but that she would look for it and let us know. The ED followed up and stated that she was unable to locate his pre-orientation training documentation prior to the exit on at 2:45 PM. CLASS I	A 025		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation.	A 081		

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A 081	Continued From page 11 The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or	A 081		

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A 081	Continued From page 12 home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living.	A 081		

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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 081	Continued From page 13 (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on review of staff records and interviews, the facility failed to provide the appropriate training for elopement for 1 of 7 staff members sampled for training. (Staff Member J) The findings include: On [redacted], a record review was conducted of staff member J, a Personal Care Assistant, which revealed no pre-orientation training on file. His date of hire was listed as [redacted]. A follow up interview was conducted with the Executive Director (ED) who stated she had done his pre-orientation training with him and was not sure why that documentation was not in his file, but that she would look for it and let us know. The ED followed up and stated that she was unable to locate his pre-orientation training	A 081		

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
	AL11911669	A. BUILDING: _____ B. WING _____	04/14/2023

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A 081	Continued From page 14 documentation prior to exit on . . . . at 2:45 PM. CLASS III	A 081		