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
	AL11966506	A. BUILDING: _____ B. WING _____	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR AT SHELL POINT (THE)	8100 ARBOR COURT FORT MYERS, FL 33908

(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 complaint survey for complaint #2023008485 was conducted on . . through at The Arbors at Shell Point, an assisted living facility in Fort Myers, Florida. Complaint #2023008485 was unsubstantiated. The following is a description of the deficiencies found at the time of the survey.	A 000		
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 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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A 032	Continued From page 1 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 staff and family interviews, and record review, the facility failed to provide supervision to a known _____ resident in order to prevent elopement for 1 (Resident #1) of 1 resident	A 032		

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A 032	Continued From page 2 reviewed for elopement. Failure to provide supervision lead to Resident #1 being lost and laying on the ground for 3.5 hours before being found. The findings included: Record review of Resident #1's diagnosis list from [redacted] included: [redacted], acute [redacted] injury, [redacted], acute [redacted], with underlying [redacted]. Record review of the incident tracking report dated [redacted] detailed the elopement of Resident #1. A Resident Caregiver was not able to locate Resident #1 on [redacted] at 3:40 p.m. for medication assistance. The staff looked for Resident #1 on the facility grounds, building and all rooms were checked and were not able to locate him. The family was contacted around 4:00 p.m. and used their tracking device located on Resident #1's walker and reported the resident's location to the facility. One hour later the family re-verified the location. Security was contacted on [redacted] at 4:45 p.m. and the Administrator and Director of Nursing were contacted on [redacted] at 5:00 p.m. The police were contacted at an unidentified time and Resident #1 was located at 6:55 p.m. The [redacted] was called and Resident #1 was taken to the hospital for treatment. On [redacted] at 2:16 p.m., during an interview, Resident 1's family revealed the facility had communicated with the family about the resident [redacted] outside. The family had hired an outside caregiver Monday through Friday to be with the resident, but the incident happened on a Saturday. The family said the facility had discussed the risks of Resident #1's [redacted]	A 032		

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A 032	Continued From page 3 and the family decided not to place the resident in a secured facility. The family placed a tracker on Resident #1's walker to track him and the facility would call the family member when the facility was unable to locate him and the family would inform the facility of Resident #1's location. The family verified that this elopement was not the first time they had used the tracker to locate Resident #1 while at this facility. On . . . at 2:00 p.m., during an interview, the Director of Healthcare Compliance (DHcC) said that Resident #1 was found 1/8th of a mile from the facility but on the campus. The resident had . . off the sidewalk behind bushes and the people searching for him didn't find him due to laying on the ground behind the bushes. The DHcC could not remember exactly who found the resident, but it was not the facility staff, it was the emergency personnel who found him while community staff were out looking as well. She said that he had a habit of . . . around the facility but had not gone very far. The daughter had put a tracking device on the walker and if the staff could not find the resident the staff would call the daughter and she would report where he was at to them. On . . . . at 12:58 p.m., during an interview, the Acting Executive Director said that Resident #1 did not have a history of . . . . . away from the facility while outside and would stay close to the building and work with the plants. The Acting Executive Director stated that Resident #1 had a habit of . . . . . around the facility but had not gone very far before. Class II .	A 032		

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A 083	Continued From page 4	A 083		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on staff interview, and record review, the facility failed to ensure a staff member with valid ( ) certification was in the facility at all times for 1 8-hour shift (-10:00 p.m. - 6:00 a.m.) out of and 's work schedules reviewed. The findings included: Record review of the Care Staff schedule from to revealed the had scheduled Staff A, B, and C for the	A 083		

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A 083	Continued From page 5 10:00 p.m. - 6:30 a.m. shift and there was no one in the building with approved certification. Staff A had certification from from the National Health and Safety Association. The provider is not accredited by the Commission on Accreditation for Pre-Hospital Education. (CAPCE) Staff B had certification from from the NationalCPRFoundation. The provider is not accredited by the Commission on Accreditation for Pre-Hospital Education. (CAPCE) Staff C had certification from from the American / Association. The provider is not accredited by the Commission on Accreditation for Pre-Hospital Education. (CAPCE) During an interview on at 3:00 p.m., the Acting Executive Director and Director of Outpatient Services confirmed that on the 10:00 p.m. - 6:00 a.m. shift did not have an employee in the building with a valid certification. Class III	A 083		