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
	AL11953648	A. BUILDING: _____ B. WING _____	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE SARASOTA	4540 BEE RIDGE ROAD SARASOTA, FL 34233

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A 000	Initial Comments An unannounced complaint survey for #2023011707 & #2023013765 & #2023013796 & #2023016805 & #2024000426 & #2024009230 were completed on through at American House Sarasota, an assisted living facility in Sarasota, Florida. Complaint 2023011707 had 2 allegations which were not substantiated. Complaint 2023013765 had 1 allegation which was not substantiated. Complaint 2023013796 had 2 allegations 1 of which was substantiated with citations at A0025 and A0032. Complaint 2023016805 had 1 allegation which was substantiated with citations at A0025 and A0032. Complaint 2024000426 had 2 allegations 1 of which was substantiated without citation. Complaint 2024009230 had 3 allegations of which 1 was substantiated with citations at A0025 and A0032. The following is a description of the deficiencies. .	A 000		
A 025 SS=K	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	A 025		

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facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition.

59A-36.007 Resident Care Standards.
An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.
(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, 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

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A 025	Continued From page 2 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 interviews, the facility failed to provide adequate supervision and did not maintain the general awareness of resident whereabouts to prevent the elopement of 4 (Residents #1, #2, #3, #4) of 28 residents reviewed. The findings included: Review of the American House Elopement Policy and Procedures Manual Policy Number WEL-36-Elopement Effective Date: and Revision Date: . Title: Elopement. Policy: It is the American House policy to ensure safety procedures are implemented to strive, prevent, identify, and respond to resident elopements. Purpose: To ensure safety. Prevention: All American House residents will be properly assessed for elopement potential. Community settings will be maintained, and staff training will be current and ongoing to provide a safe living environment. 1. Record review of Resident #1's record showed an admission date of . The Health Assessment Form 1823 (HA Form 1823) listed a diagnosis of and identified the resident as an elopement risk on . Record review of the facility incident log, showed Resident #1 had an elopement on . She left the facility's 3rd floor Memory Care Unit and	A 025		

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exited through the stairwell at 6:50 p.m. and was found on at 7:05 p.m. by Villa 6 within the campus, approximately 200 from the main building where the resident resides. There was no documentation the facility implemented corrective actions, including adequate monitoring to prevent further incidents of unsafe and elopement.

Record review of the facility incident log revealed on , Resident #1 eloped through the 3rd floor Memory Care Unit stairwell exit at 3:57 p.m. and was found at the entrance of the parking lot at 4:03 p.m. The family was notified and provided a companion to the resident for 48 hours. There was no documentation of additional interventions including increased supervision implemented after the 48 hours of private duty companion provided by the family. The facility's corrective actions were to install screamers to the 3 exit doors to the Memory Care Unit; however, this did not occur until .

On , a note in Resident #1's record documented staff were to encourage the resident to stay in the common area and participate in activities.

Record review of the facility incident log revealed on , Resident #1 eloped from the 3rd floor Memory Care Unit stairwell exit at 12:48 p.m. and the resident was found walking past the entrance of the facility, East on the sidewalk of Bee Ridge Road unsupervised and was picked up by the Wellness Director in her car at 12:54 p.m. Bee Ridge Road is a six-lane main thoroughfare with a speed limit of 45 mph.

Record review revealed on , Resident #1's responsible party was provided a 45-day

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A 025	Continued From page 4 discharge notice. The resident was placed on one-to-one supervision for two days, with no further increased supervision was implemented from through the discharge date of . Record review of an email communication from the Regional Wellness Director, dated - showed 3 screamer alarms that were delivered and ordered to be installed by the Maintenance Director on . The Maintenance Director replied to the from - and verified their installation. An email communication dated from a Regional Wellness Director, documented a 4th extra screamer alarm that was delivered on . 2. Record review of Resident #2's record showed an admission date of . The HA Form 1823 listed diagnoses of and , and identified the resident as an elopement risk. Record review of the facility incident log revealed on , Resident #2 eloped from the 3rd floor Memory Care Unit stairwell exit at 12:38 p.m. Medication Technician (Med Tech/MT) Staff C responded to the alarm and observed another resident by the door and thought that resident set off the alarm. MT Staff C did not initiate the elopement protocol and the alarm without initiating a missing resident search per the facility's policy. On at 12:40 p.m., Staff D went to check on Resident #2 and could not locate him in his room. On at 12:53 p.m., staff notified the Executive Director and Wellness Director that Resident #2 could not be found and the elopement procedure was initiated. On at 1:26 p.m., the Wellness Director	A 025		

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A 025	Continued From page 5 found Resident #2 walking down the sidewalk on McIntosh Road. McIntosh Road is a crossroad of Bee Ridge Road at the stop light 2.2 miles away. McIntosh is a busy 4 lane road with the speed limit if 45 MPH. On , the HA Form 1823 was updated to reflect the resident's elopement risk. The corrective actions included: Adding screamer alarms to the doors (installed on &), door wraps that appear to look like bookshelves (or). They sent a request to the Fire Marshall to enquire about a Knox Box to each door and to keep 3 of the 4 exit doors locked. They contacted the nurse call system to see if there is a way to ping the resident's alarm. (Not initiated as of). No additional interventions were implemented to ensure adequate supervision of the resident to prevent unsafe and elopement. 3. Record review of Resident #3's record showed an admission date of . The HA Form 1823 listed a diagnosis of . The HA Form 1823 did not document the resident as an elopement risk. Record review of the facility incident log revealed on at 8:15 a.m., Resident #3 eloped from the 3rd floor Memory Care Unit stairwell exit. The resident was found by Staff A at 8:18 a.m. on the stairs and returned the resident to the Memory Care Unit. Staff notified Resident #3's son and the Primary Care Provider. No additional interventions were implemented to ensure supervision of the resident to prevent unsafe and elopement. There was no documentation the facility updated the HA Form 1823 to reflect the resident's risk for	A 025		

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elopement.
No increased supervision was documented as being implemented.

4. Record review of Resident #4 showed an admission date of . The HA Form 1823 listed a diagnosis of . The 1823 identified the resident as being an elopement risk.

Record review of the facility incident log revealed on at 1:29 p.m., Resident #4 eloped from the 3rd floor Memory Care Unit out the stairwell exit. Staff B arrived at the stairwell exit door at 1:31 p.m. as she looked through the window of the door and did not see anyone. She tried to silence the alarm but did not know how, so she went and got Staff A, who responded and proceeded to reset the alarm at 1:32 p.m.

There is no documentation to indicate after the alarm went off and was reset by Staff A, that an investigation was conducted to find out why the alarm went off. There was no documentation a count was conducted of residents to verify that all residents were accounted for and safe in the facility.

Record review of the facility incident log revealed on at 2:28 p.m., Resident #4 was located on a bench in the breezeway of the building. (the breezeway is a covered area located down 3 flights of stairs and outside of the memory care unit between two buildings). The resident was escorted to the memory care unit.
No additional interventions were implemented to ensure supervision of the resident to prevent unsafe and elopement; no increased supervision was implemented.

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During an interview on at 4:45 p.m., the Memory Care Director said that on the camera we saw that he (Resident#4) had gotten out of one of the side doors. The housekeeper had a moment of panic and asked for help. One of our RAs (Staff A) turned off the alarm as she didn't see anyone. They assumed that it was another resident. Resident #4 had called his wife and asked to be picked up as she does not live on the premises. They didn't notice that he was gone until way later. During shift change, one of our RAs noticed he wasn't here. They eventually noticed he was gone and did a count and did elopement procedures at that time. Typically, our process is that the alarms remain on until we have , on the resident. In this case, they were turned off.

On at 3:45 p.m., Med Tech Staff F said Resident #4 is an elopement risk. We had to take him out the door and walk him around. We called his wife, and she was able to calm down slightly. He was sitting in a chair, and we had to push him into the Memory Care Unit.
Med Tech Staff F said Resident #2 knows that his wife comes up here a lot and stays on the 3rd floor and he is "up" after she comes to see him. After her visit he is usually very active.
My first time working a shift we had Resident #7, and Resident #8, and they were pushing another resident, and they got out. We went out and found all 3 of them right outside the unit walking together.
Resident #2 will rile all the residents up and try to get them going to the door.
I did MyALF.com Elopement Response Training when I came on board. (MyALF.com is an online generic training provider and does not teach from the Facility's policy and procedures as required by Rule.)

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A 025	Continued From page 8 Resident #12 is definitely a risk. She is new, but she tends to and never gets tired. I talked to the Wellness Director about getting something for Resident #12 because she never gets any breaks. She is tired, you can see it in their , . Class II .	A 025		
A 032 SS=K	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 all residents assessed at high risk for elopement	A 032		

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A 032	Continued From page 9 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 review, and observation, the facility failed to ensure that all residents at risk for elopement, or with any history of elopement, were properly identified so staff can be alerted to their needs for support and supervision and prevent	A 032		

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elopement for 4 (Residents #1, #2, #3, and #4) of 28 residents. Further the facility also failed to ensure that 16 (Staffs H, K, N, R, W, Z, AA, BB, EE, JJ, LL, OO, VV, WW, YY, AAA) of 57 staff reviewed, had documentation of participation in a minimum of 2 resident elopement drills each year; and further failed to provide the required Facility procedural based Elopement Response Training to 50 (Staffs E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Z, AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC) out of 57 administrative and direct care staff reviewed.

The findings included:

1. Record review of Resident #1's record showed the date of admission as . The Health Assessment Form 1823 (HA Form1823) listed the diagnosis of . The HA Form 1823 did not identify the resident as an elopement risk on .

Record review of facility incident report for Resident #1 showed that on , the alarm to the exit door to the stairwell (next to) went off at 6:50 p.m. Resident #1 was found on at 7:05 p.m. by Villa 6 within the campus, approximately 200 of the main building where the resident resides.

Record review of facility incident report for Resident #1, showed that on at 3:57 p.m., the alarm to door by , the stairwell exit, went off. Staff responded to the alarm. Resident #1 was found at the entrance to the parking lot at 4:03 p.m.

Record review of facility incident report for

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Resident #1, showed that on at 12:48 p.m., the alarm went off on the southeast stairwell (by). Staff responded to the alarm, went down the stairs. The incident report noted at 12:50 p.m., the Executive Director observed the resident from the second-floor window walking in the parking lot. Resident #1 was heading toward the entrance of the property.
On at 12:52 p.m., the Wellness Director got in her car and went to the entrance. She saw Resident #1 walking east on the sidewalk on Bee Ridge Road. Bee Ridge Road is a busy six-lane road; the speed limit is 45 M.P.H.
On at 12:54 p.m., the Wellness Director picked up the Resident.

2. Record review of Resident #2's record showed an admission date of . The HA Form 1823 listed a diagnosis of and .
The HA Form 1823 also identified the resident as an elopement risk. Resident #2 currently resides in the Memory Care Unit of the facility.
Record review of facility incident report showed that on at 12:30 p.m., the resident's spouse who was visiting left the facility.
On at 12:33 p.m., Resident #2 headed toward the exit door to follow his wife. Staff redirected the resident to the dining area.
On at 12:38 p.m., the alarm to the door by went off. Staff C responded to the alarm and observed a resident by the door. She thought the resident set off the alarm.
Staff C did not initiate the elopement protocol and the alarm without initiating a missing resident search per the facility's policy.
On at 12:40 p.m., Staff D went to check on Resident #2 and could not locate him in his room.
On at 12:53 p.m., staff D notified the Executive Director and Wellness Director that

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A 032	Continued From page 12 Resident #2 could not be found. On at 1:26 p.m., the Wellness Director found Resident #2 walking down the sidewalk on McIntosh Road. McIntosh Road is a crossroad of Bee Ridge Road at the stop light 2.2 miles away. McIntosh is a busy 4 lane road with the speed limit if 45 M.P.H. 3. Record review of Resident #3's record showed an admission date of . The Resident's HA Form 1823 showed a diagnosis of . The HA Form 1823 did not document the resident as an elopement risk. Record review of facility incident report revealed on at 8:15 a.m., the door alarm went off, Staff A heard the door alarm and responded to the door and found the resident on the stairs. Staff redirected the resident into the facility and returned the resident to the Memory Care Unit at 8:18 a.m. The resident was treated for a ({[ ], which can cause mental disturbances in the elderly and sudden onset of or ; especially prominent in individuals with). 4. Record review of Resident #4's record showed an admission date of . The HA Form 1823 showed a diagnosis of , , . The HA Form 1823 documents the resident as being an elopement risk. Resident # 4 currently resides in the memory care unit of the facility. Record review of the facility incident log revealed on at 1:29 p.m., Resident #4 went through the fire exit door at the end of the south hallway by . The screamer alarm went off and the housekeeper Staff B arrived at the door at 1:31 p.m. She looked through the window of the door and did not see anyone, and she tried	A 032		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE SARASOTA	4540 BEE RIDGE ROAD SARASOTA, FL 34233

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to silence the alarm but did not know how, so she went and got Staff A who responded to the alarm at 1:32 p.m. and proceeded to turn off and reset the alarm.

On at 2:28 p.m. Resident #4 was located on a bench in the breezeway of the building. (the breezeway is a covered area located down 3 flights of stairs and outside of the memory care unit, between two buildings). The resident was escorted to the memory care unit.

On at 3:45 p.m., Resident #4 was observed to be exit-seeking on the Memory Care Unit. Resident #4 was heading toward the door to the third-floor entrance. Staff were seen following the resident and attempted to redirect him. He continued down the hallway and staff members were seen with him attempting to redirect him to the common area.

5. Review of the American House Elopement Policy and Procedures Manual Policy Number WEL-36-Elopement Effective Date:
and Revision Date: .
Procedure: Drills:
7. The Executive Director/Designee will ensure that staff receives proper training pertaining to elopement procedures during initial orientation and yearly.

Record review on of the Active Employee Headcount by Job Assignment (AEHJA) showed a total of 7 administrative staff and 46 direct care staff employed by the facility.

a. Review of the AEHJA showed that Medication Technician (MT) Staff H was hired on .
There was no documentation of Staff H

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participating in any of the elopement drills reviewed and there was no documentation of completion of the required Elopement Response training.

b. Review of the AEHJA showed that administrative Staff K was hired on . There was no documentation of Staff K participating in any elopement drills. Documentation of their elopement response training certificate on does not meet the in-service training requirements as it was on-line web based general elopement training and not the Facility's Elopement Response Procedure.

c. Review of the AEHJA showed that Resident Assistant ( ) Staff N was hired on . There was documentation of Staff N participating in an elopement drill only on . There was no documentation of completion of the required Elopement Response Training.

d. Review of the AEHJA showed that MT Staff R was hired on . There was documentation of participating in an elopement drill only on . Documentation of their elopement response training certificate on does not meet the in-service training requirements as it was on-line web based general elopement training and not the Facility's Elopement Response Procedure.

e. Review of the AEHJA showed that Staff W was hired on . There was documentation of Staff W participating in an elopement drill only on and . There was no documentation of completion of the required Elopement Response Training.

f. Review of the AEHJA showed that MT Staff Z

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was hired on . There was no documentation of Staff Z participating in any elopement drills and there was no documentation of completion of the required Elopement Response Training.

g. Review of the AEHJA showed that MT Staff AA was hired on . There was documentation of Staff AA participating in 2 elopement drills, but not 2 drills annually, only on and . There was no documentation of the required Elopement Response Training.

h. Review of the AEHJA showed that administrative Staff BB was hired on . There was no documentation of participating in any elopement drills and there was no documentation of the required Elopement Response Training.

i. Review of the AEHJA showed that Licensed Practical Nurse (LPN) Staff EE was hired on . There was documentation of participating in 2 elopement drills annually, only on . There was no documentation of the required Elopement Response Training.

j. Review of the AEHJA showed that MT Staff JJ was hired on . There was no documentation of Staff JJ participating in any elopement drills and there was no documentation of the required Elopement Response Training.

k. Review of the AEHJA showed that MT Staff LL was hired on . There was documentation of Staff LL participating in 2 elopement drills, but not 2 drills annually, only on and . There was no documentation of the required Elopement Response Training.

l. Review of the AEHJA showed that Staff OO

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A 032	Continued From page 16 was hired on . There was no documentation of Staff OO participating in any elopement drills and there was no documentation of the required Elopement Response Training. m. Review of the AEHJA showed that MT Staff VV was hired on . There was documentation of Staff VV participating in only one elopement drill on . There was no documentation of the required Elopement Response Training. n. Review of the AEHJA showed that Staff WW was hired on . There was documentation of Staff WW participating in only one elopement drill only on . There was no documentation of the required Elopement Response Training. o. Review of the AEHJA showed that Staff YY was hired on . There was no documentation of Staff YY participating in any elopement drills and there was no documentation of the required Elopement Response Training. p. Review of the AEHJA showed that administrative Staff AAA was hired on . There was no documentation of participating in any elopement drills and there was no documentation of the required Elopement Response Training. Further record review revealed the following personnel records did not contain any required Elopement Response Training: q. Review of Staff I's staff record showed a hire date of . r. Review of MT Staff J's staff record showed a hire date of .	A 032		

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s. Review of MT Staff L's staff record showed a hire date of .
t. Review of MT Staff M's staff record showed a hire date of .
u. Review of MT Staff O's staff record showed a hire date of .
v. Review of MT Staff S's staff record showed a hire date of .
w. Review of MT Staff U's staff record showed a hire date of .
x. Review of Wellness Director's staff record showed a hire date of .
y. Review of Staff X's staff record showed a hire date of .
z. Review of the Memory Care Director's staff record showed a hire date of .
aa. Review of Staff CC showed a hire date of .
bb. Review of MT Staff F's staff record showed a hire date of .
cc. Review of direct care LPN Staff GG's staff record showed a hire date of .
dd. Review of Staff II's staff record showed a hire date of .
ee. Review of Staff KK's staff record showed a hire date of .
ff. Review of MT Staff NN's staff record showed a hire date of .
gg. Review of MT Staff QQ's staff record showed a hire date of .
hh. Review of MT Staff ZZ's staff record showed a hire date of .
ii. Review of administrative Staff CCC's staff record showed a hire date of .

Further record review revealed the following personnel records contained training completed using the on-line web based general elopement training and not the Facility's Elopement Response Procedure:

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A 032	Continued From page 18 jj. Review of Staff MM's staff record showed a hire date of and documentation of "MyALF.com" elopement response training certificate on . kk. Review of direct care Staff PP's staff record showed a hire date of and documentation of "MyALF.com" elopement response training certificate on . ll. Review of RR's staff record showed a hire date of and documentation of "MyALF.com" Elopement Response Training certificate on . mm. Review of MT Staff SS's staff record showed a hire date of and documentation of "MyALF.com" Elopement Response Training certificate on . nn. Review of MT Staff TT's staff record showed a hire date of and documentation of "MyALF.com" Elopement Response Training certificate on . oo. Review of MT Staff UU's staff record showed a hire date of documentation of "MyALF.com" Elopement Response Training certificate on . pp. Review of MT Staff XX's staff record showed a hire date of and documentation of "MyALF.com" Elopement Response Training certificate on . qq. Review of MT Staff BBB's staff record showed a hire date of and documentation of "MyALF.com" Elopement Response Training certificate on . rr. Review of MT Staff T's staff record showed a hire date of and documentation of "MyALF.com" Elopement Response Training certificate on . ss. Review of Staff P's staff record showed a hire date of and documentation of "MyALF.com" Elopement Response training certificate on .	A 032		

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A 032	Continued From page 19 tt. Review of Staff Q's staff record showed a hire date of and documentation of "MyALF.com" Elopement Response Training certificate on . uu. Review of Staff DD's staff record showed a hire date of and documentation of "MyALF.com" elopement response training certificate on . vv. Review of MT Staff E's staff record showed a hire date of and documentation of "MyALF.com" Elopement Response Training certificate on . ww. Review of Staff FF's staff record showed a hire date of documentation of "MyALF.com" Elopement Response Training certificate on . xx. Review of Staff HH's staff record showed a hire date of and documentation of "MyALF.com" Elopement Response Training certificate on . yy. Review of MT Staff G's staff record showed a hire date of and documentation of "MyALF.com" Elopement Response Training certificate on . Class II .	A 032		