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
	AL11969020	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDERMERE MEMORY CARE INC	7901 KIPLING ST PENSACOLA, FL 32514

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A 000	Initial Comments An unannounced complaint survey for complaint #2025000873 was conducted on - at Windermere Memory Care Assisted Living Facility in Pensacola, FL. At the time of the survey, deficient practice was identified. A Class I deficiency was identified at A0025, related to resident supervision. A Class I deficiency is a deficiency that the Agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility.	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 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 is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the	A 025		

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A 025	Continued From page 1 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, family interview and staff interview, the facility failed to provide appropriate supervision for 1 of 16 residents (Resident #1) who had been assessed as being elopement	A 025		

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risks. Due to the lack of supervision, Resident #1 was able to leave the memory care unit undetected and was later found outside in the facility's enclosed courtyard in the snow. Emergency Medical Services ( ) responded, and Resident #1 was transported to a hospital and recieved agressive re-warming measures for , but was ultimately pronounced . The facility's lack of appropriate supervision resulting in Resident #1's elopement and subsequent resulted in a Class I deficiency.

On the evening of the event, , it was actively snowing with an outside temperature in the low to mid 20's.

The findings included:

Review of the facility's investigation dated indicated, "Between PM, [Resident #1] was redirected into the dining room area for dinner. [Resident #1] was seen in the dining room between PM. [Staff D, a medication technician] passed out medications to residents. [Resident #1] was changed into her pajamas and placed in bed around 7:30 PM by [Staff B, a patient care assistant]. [Staff A, the Health Care Coordinator] told staff to check on resident, [Staff B] reported resident was not in bed. Team began searching outside. [Resident #1] was found outside near the activity room. [Staff A, B, C (another medication tech) , and G (another patient care assistant)] carried her inside the facility while [Staff D] called 911. Staff stated Resident #1 had a , and on her and . Emergency Medical Services ( ) arrived between :10pm. Called family, Hospital called and stated time of was around

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A 025	Continued From page 3 10pm. Spoke to hospice and husband the next day. Currently in contact with medical examiner". Review of the weather in the area of the facility on the day of the incident, Weather.gov reported the area received approximately 10 inches of snow and had an overnight low temperature of 16 degrees Farenheit. A review was conducted of Resident #1's two most recent Health Assessments, Form 1823, dated and . The health assessment dated indicated that Resident #1 was assessed to be an elopement risk and had a history of eloping. The health assessment dated indicated that Resident #1 was not an elopement risk. Resident #1 had a medical history significant for , , type II , , , , , and 's with . Review of the Advanced Registered Nurse Practitioner's (ARNP) report dated from the 's (PD) Screening Tool indicated the facility staff had identified Resident #1 might have been experiencing symptoms of 's . This reported indicated that Resident #1 had been previously diagnosed with 's by another physician. The report indicated, "descriptions of symptoms/impact on resident: [Resident #1] was attempting to elope from facility; tried to elope multiple times on the weekend of - - jumped out of a window, dug under a fence, and broke fence boards. [Resident #1] was having temper tantrums. Resident believes husband was having an affair. [Resident #1] stated that she sees him and the other women naked in front of her children. [Resident #1] thinks husband was	A 025		

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deceiving her and getting a divorce. [Resident #1] cries daily, throws tables and complains of her "feeling funny"."

Review of Staff A, Health Care Coordinator's (HCC A) Observation Notes for Resident #1 revealed on , Staff A documented "Resident still walking freely in and outside of the building. Resident has been brought inside several times on this shift. Resident came in for a 30-minute break, got some rest. Repeated all night". Further review of Staff A's notes revealed on they documented, "Resident still seeking exit". Continued review of HCC A's notes revealed on , they wrote, "found resident outside sitting down inside courtyard. Still exit seeking".

Review of Staff C, Patient Care Assistant's (C) Observation Notes for Resident #1 revealed on , C documented, "Resident found outside digging at gate. Redirected her to room cleaned her up. Put her in bed". Later the same day, C wrote, "Resident found outside talked to her that it's too dark, redirected her to set in office with medication technician".

Review of Staff G, 's Observation Notes for Resident #1 revealed on , G documented, "From PM, I redirected Resident from exit doors. 4:00pm redirected resident inside. At 5:00 PM, Resident was redirected inside".

Review of Staff B, 's Observation Notes for Resident #1 revealed on , B documented, "3 PM to 4 PM found resident outside, changed her clothing made sure she was ok. 4 PM to 5 PM, redirected resident inside,

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A 025	Continued From page 5 laid her down in her room". On at approximately 11:25 AM, an interview was conducted with the facility's owner, who reported the exit doors that lead to the outdoor courtyard were supposed to have working alarms. The owner reported the facility had video cameras in public areas to aid in monitoring the location of residents and the cameras were operational at all times. The owner reported that she could not review the video footage with the surveyor but instead presented a written timeline for the video along with screenshot pictures from the video footage for the surveyor to review. During review of the written timeline and screenshots, the surveyor noted the timeframe on from 7:06 PM to 7:43 PM, the timeframe that Resident #1 was found to be out of her room, was not available and no screenshots were provided for surveyor review. The owner was not able to provide a reason for why this portion of the video was missing. When asked about Resident #1's history at the facility, the owner reported Resident #1 had eloped one time from the facility. She elaborated that Resident #1 had left the facility grounds and was found next door at the skating rink. The owner reported that Resident #1 "was not a , but she just piddles around the facility; she said, "she would go in and out of the building to the courtyard but never tried to leave the gates that surround the perimeter." The owner reported that she was not at the building on the night of , the night of the snowstorm, but that staff had contacted her about the incident. On at approximately 11:32 AM, an interview was conducted with HCC A who reported that she found Resident #1 outside the night of . HCC A recalled Resident #1 was	A 025		

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A 025	Continued From page 6 ˇ in the kitchen around 6:30 PM after dinner, so she asked B to get Resident #1 ready for bed because she knew Resident #1 liked to go outside. She further recalled around 7:30 PM she asked B to check on Resident #1 to ensure she was in her room. When B arrived at Resident #1's room, she was not in her bed. B reported to HCC A that Resident #1 was not in her bed and the staff began looking for Resident #1. HCC A recalled Resident #1 was found outside near the activity door, laying on the ground on top of snow. She stated arrived around 8:00 PM and the facility received a call from the hospital around 10:00 PM stating they had pronounced Resident #1 . When asked how the staff monitor residents for safety, HCC A stated there were video monitors in the medication office that the staff used to "see around the building". When asked how many residents were eloplement risks, HCC A stated "only two like to go outside, [Resident #1] and" one male resident. Of the male resident, HCC A further stated "once he goes to bed, he is out and will not get up". When asked if the facility provided in-services or training on elopements and door safety, HCC A stated that we were reminded to check on the residents and to ensure all alarms were working. They have talked to us and have been encouraging us to check on residents more frequently, but no formal in-service. On at approximately 11:51 AM, an interview was conducted with C who reported that Resident #1 was an elopement risk. C reported that Resident #1 was not on one-to-one supervision, but that staff would do 30-minute to one-hour checks because Resident #1 was always exit seeking.	A 025		

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A 025	Continued From page 7 On at approximately 12:32 PM, an interview was conducted with Staff F, , who reported that she was not working on the night of the incident, but stated she could confirm that Resident #1 was an elopement risk and must be watched all the time because she likes to and is always exit seeking. On at approximately 2:48 PM, a telephone interview was conducted with Resident #1's husband. The husband reported that just days before the snowfall he warned Staff E, to watch his wife carefully because she liked to go outside. He stated, "I told them on that Saturday, 'you know she goes outside, if it's going to snow, you need to make sure she does not go outside' ". The husband reported Resident #1 had "many times while going out into the courtyard". The husband reported that Resident #1 was known for going outside. He stated that, on one occasion when he visited Resident #1 at the facility, he found her outside and had to get a wet cloth and put it on her forehead to cool her down. He stated that she had escaped at least four times from the facility and was found up and down the road opposite the facility near a church. He clarified that Resident #1 had not crossed the street but stayed on the side of the street where the facility was located. The husband stated that the facility had to call the police on one occasion to bring her . The husband reported that Resident #1 used to wear a detection bracelet on her ankle, but it was taken off. The husband reported he called the hospital on the night of after staff from the facility had informed him of the incident. The husband stated he was calling to check on his wife and never expected to hear the hospital pronounce her around 10:00 PM. The husband reported he was informed by the hospital that his wife's body	A 025		

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temperature was 75 degrees Fahrenheit at the emergency room. The husband reported the hospital informed him that they worked on his wife for about an hour attempting to increase her body temperature before she was pronounced .

On at approximately 12:43 PM an interview was conducted with Staff D, Medication Technician (MT), who reported she was working at the facility the night of the incident with Resident #1. MT D reported that all staff knew Resident #1 was a . She stated that the last time she saw Resident #1 was around 6:00 PM that evening during dinner and then around 6:15 PM when she provided Resident #1 her evening medications. MT D reported that she assisted with the search for Resident #1. MT D reported Resident #1 was found outside at the of the building near the activity room door by the handrail. MT D reported Resident #1 was found lying on the ground on top of the snow making moaning sounds, and she had scratches on both and on the right side of her forehead. MT D reported that Resident #1 was trying to get up, but couldn't get up on her own as she was not able to bear and was not able to walk, so staff carried her inside the facility. MT D further recalled that C and HCC A took Resident #1 to her room where they removed her wet clothes, dried her off and tried to warm her up her body. MT D reported she called . MT D reported staff are required to do 2-hour checks to make sure all residents are in the building. MT D reported that Resident #1 and tried to exit seek a lot.

On at 9:47 AM an interview was conducted with Staff E, , who reported that she had worked at the facility for about three

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years. E reported that she was familiar with Resident #1's husband, who came to visit two to three times a week for about 2 hours. E denied speaking with Resident #1's husband the weekend before the incident. E reported that Resident #1 was known for going outside and trying to find places to get out of the gates that surround the perimeter, and recalled at least 5 to 10 instances of this occurring. E reported that Resident #1 would try to get outside the gates, feel on the fences and building by using a pushing motion, and was generally exit seeking.

E reported all staff were aware of Resident #1's exit seeking behaviors. E reported staff would redirect Resident #1 inside the facility.

E reported Resident #1 was on 1-hour checks. E reported staff checked the doors every day throughout the shift and turned the alarms on at night around 9:00 PM and turned them off at 7:00 AM. E reported that a camera was placed on hallway 2 and would have shown Resident #1 coming out of her room on the night of the incident. E confirmed that this camera is supposed to be working 24 hours a day.

On at 2:52 PM an interview was conducted with Staff B, who reported that she had worked at the facility for about two months. B reported that the night of the incident, she was assigned to work with Resident #1, who had tried to exit seek at least four times or more. B reported that Resident #1 moved around the facility a lot and regularly went into the courtyard and had to be redirected inside.

B stated, "she would be all over the place".

B reported Resident #1 would go out and walk around in circles, in and out of the building.

B reported that Resident #1 left the building about 2 times the night of incident around 5:00

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PM. B reported she immediately went out and redirected Resident #1 to the facility by talking to her. B reported on the evening of around 7:00 PM, she had to put other residents to bed, so she laid Resident #1 in bed and then went to the Medication Technicians office where she located HCC A, MT D and C. B reported she informed the three staff members that she had just laid Resident #1 down in bed. B clarified she didn't say verbally to watch her, but the staff knew to watch her because she would get up out of the bed. B reported that there was a video monitor in the Medication Technicians office, and staff could watch the monitor to see if a resident left their room. B reported that she put the rest of her residents in bed and, at 7:30 PM, she went to check on Resident #1 and discovered she was not in her bed. B stated she informed the staff in the Medication Technicians office, and they began to search for Resident #1, observing the video monitor screens. B reported that she was able to see footprints out by the smoking patio door. B reported that they ran outside searching for Resident #1 and, once outside, they found Resident #1 lying on top of the snow by the activity door. B reported that one side of Resident #1's was covered in snow. B reported Resident #1 was grunting and could not stand. B stated that Resident #1 was taken to her room and her wet clothing was removed. B reported that she was concerned for Resident #1 because her skin was pale.

On at approximately 4:43 PM, a telephone interview was conducted with the ARNP who reported that she had been Resident #1's primary care provider since . The ARNP stated Resident #1 was an elopement risk. The ARNP stated that Resident #1 always tried to

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A 025	Continued From page 11 find a way out, going outside to try to exit seek. The ARNP stated that, when she visited the facility on , she was informed by staff that Resident #1 was found outside on her digging under the fence, trying to get out. The ARNP stated that she completed the 1823 Health Assessment Form dated in 2022, and noted that Resident #1 was an elopement risk, and she continued to be an elopement risk. The ARNP stated that the 1823 Health Assessment dated , which indicated that Resident #1 was not an elopement risk, was completed by a hospital physician who did not know Resident #1's history. The ARNP reported that Resident #1 had broken fences, would break doors, and, on one occasion, she went out the front entrance door behind a delivery person. The ARNP stated when Resident #1 was admitted to the facility, she was an elopement risk. The ARNP stated that Resident #1 started , that her husband was cheating on her and she would attempt to get out to go find him. The ARNP stated Resident #1 was put on Hospice when she became weaker and began to have problems. On at approximately 9:26 AM, an interview was conducted with the facility's Executive Director (ED) who reported that the night of the incident, she was not at the facility. The ED reported that the facility's outside surroundings had motion sensor lights and, if a resident was outside walking, a motion senor light would come on to alert that someone or something was outside. The ED reported that staff usually checked outside if a motion light came on. The ED confirmed that Resident #1 was an elopement risk, an exit seeker, and a lot. The ED reported that Resident #1 was not on one-to-one observation.	A 025		

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A 025	Continued From page 12 A review was conducted of Resident #1's hospital Emergency Provider Report dated , which indicated a chief complaint of " exposure". The report documented the primary cause of was " ", and the primary impression was " due to exposure". The report also indicated that, according to the staff at the facility, Resident #1 had a when they found her, so they placed her in bed and called the ambulance. Upon arrival of Emergency Medical Services ( ), Resident #1 was pulseless and was in fine . placed an endotrachial tube, started ( ), gave and , and defibrillated Resident #1 more than 10 times and started advanced life support (ACLS) protocol with Lund University System (Lucas) device. was on scene at 8:15 PM and arrived at the hospital at 9:07 PM. The report documented a body temperature at 76.8 degrees Fahrenheit, and noted the clinical presentation was characteristic of severe as the cause of her . The report indicated that hospital staff started aggressively re-warming both externally and internally. Resident #1 was given 3 liters of warmed fluids through the rapid infuser. Additionally, a was placed and was irrigated with warmed normal , and warmed humidified was started. The report documented that these interventions failed to improve Resident #1's temperature, so tubes were placed to add ( ) irrigation at 9:45 PM. After another 40 minutes with and irrigation, the hospital was only able to increase Resident #1's core body temperature to 80 degrees Fahrenheit where it remained for 20 minutes. Further attempts to warm Resident #1 did not work. At this point, it was determined by	A 025		

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	AL11969020	A. BUILDING: _____ B. WING _____	01/29/2025

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A 025	Continued From page 13 the medical staff that Resident #1 had no chance of any meaningful recovery. This was discussed with Resident #1's husband and the ACLS protocol was discontinued. Resident #1was declared at 10:28 PM. Class I	A 025		
A 152 SS=H	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate	A 152		

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A 152	Continued From page 14 keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide a safe living environment for 1 of 17 residents reviewed who were assessed on the 1823 Health Assessment for elopement risk, (Resident #1). The facility failed to ensure door alarms were functioning as expected, and doors leading to the enclosed courtyard were secured during inclement weather. The facility failed to have a policy on securing exit doors. On the evening of , during a snowstorm, Resident #1 was able to exit the facility into the enclosed courtyard without staff knowledge. The findings included: Tours of the facility were conducted on beginning about 11:17 AM with Staff A, the Health Care Coordinator (HCC A) and the Executive Director (ED). There was a courtyard exit door located approximately 15 from Resident #1's room. The door alarm failed to sound, and when the HCC touched the alarm to verify if was operational, the bottom part of the alarm that was attached to the door on the floor. The exit bar on the inside panel of the door was locked in the "open" position. Because this exit bar was "open", the surveyor observed the door did not fully close	A 152		

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A 152	Continued From page 15 (photographic evidence obtained). Since the door did not fully close, it was easily pushed open from the inside or pulled open from the outside. During the tour, the Activity room exit door to the courtyard was checked, and no alarm sounded. The main entrance door required a code to be entered to unlock. The HCC stated that staff turn the alarms off at 7 AM and on at 8 PM. She stated that the reason the alarms are turned off was because staff and residents got tired of hearing the alarms and when the alarms sounded, it would stop residents from going outside into the courtyard. The HCC was not aware of a policy for securing exit doors. An observation was made of the southeast courtyard exit door which revealed an alarm was turned on. Closer observation revealed when the door was opened, the alarm sounded until the door closed on its own. When the door was closed, the alarm turned off. An interview was conducted with the ED at this time. The ED stated staff would not be able to hear this door's alarm unless they were in close proximity to the door. The ED confirmed the alarm turned off within approximately 5 to 7 seconds when the door closed under its own power and that staff did not need to be present to disarm the alarm. On at approximately 11:32 AM, a follow-up interview was conducted with HCC A. When asked how the staff monitor residents for safety, HCC A stated there were video monitors in the medication office that the staff used to "see around the building". When asked if the facility provided in-services or training on elopements and door safety, HCC A stated that we were reminded to check on the residents and to ensure all alarms were working. They have talked to us and have been encouraging us to check on residents more frequently, but no formal	A 152		

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A 152	Continued From page 16 in-service. On at approximately 12:43 PM an interview was conducted with Staff D, Medication Technician (MT). MT D reported staff are required to do 2-hour checks to make sure all residents are in the building. On at 9:47 AM an interview was conducted with Staff E, Patient Care Assistant ( ). E reported staff checked the doors every day throughout the shift and turned the alarms on at night around 9:00 PM and turned them off at 7:00 AM. An interview was conducted on at approximately 2:50 PM with the facility's owner concerning the courtyard exit door located within approximately 15 of Resident #1's room. The owner confirmed that the door was noted to not close properly and further stated that the exit bar was locked in the "open" position for ease of resident use. She stated if the residents wanted to go out to the courtyard area, the door would lock them out of the facility if the exit bar was not locked in the "open" position. When asked about the broken alarm on the southeast courtyard exit door , the owner stated the staff was instructed to perform rounds every morning to turn the alarms off. The owner stated she was unsure how long the alarm had been broken but that she did have replacement alarms available in her office. She further stated there were residents who liked to remove objects/decorations from the walls on occasion. The owner stated she would have the southeast courtyard exit door alarm replaced and the other door fixed to close properly. The surveyor requested the facility's policy for securing the door. The owner stated she did not have a policy. She further stated there was a	A 152		

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A 152	Continued From page 17 posted reminder for the staff in the medication room that stated the door alarms were to be turned on at 8:00 PM and off at 7:00 AM daily. On at approximately 9:26 AM an interview was conducted with the Executive Director (ED) who reported that all exit doors are supposed to have properly working alarms. The ED stated it was the responsibility of the supervisor on duty make sure all alarms are working properly, and if not working to inform maintenance. ED reported that staff turn the alarms on about 8:00 PM and off at about 7:00 AM. The ED explained that the residents are in and out throughout the day, so the alarms are turned off, because if not it would discourage the residents from going outside. The ED stated that there was no policy for the alarms. The ED stated that staff had not notified her of the broken alarm, nor had staff reported regarding the night of the incident if the alarms were on or off. The ED reported that if residents were outside walking around at night, the motion sensor light would come on which could be seen on the camera monitors. The ED reported that staff usually check outside if the motion light comes on. On at approximately 1:00 PM during the exit conference with the facility, the owner indicated that she had ordered 14 doors to replace the current exit doors that will be locked going forward. She also stated they purchased new door alarms that have a code to turn the alarm off by the staff, and were in process of installing the new alarms on the exit doors in the meantime. Class II	A 152		