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
	AL11969808	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERCREST SANTA ROSA BEACH	205 W HEWETT ROAD SANTA ROSA BEACH, FL 32459

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A 000	Initial Comments An unannounced biennial relicensure survey was conducted on through at Watercrest Santa Rosa Beach, an assisted living facility in Santa Rosa Beach, FL. A generator assessment and review of the limited nursing services license was performed during this visit. Deficient practice was identified at the time of the survey.	A 000		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the	A 165		

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A 165	Continued From page 1	A 165		

resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or
7. An event that is reported to law enforcement or its personnel for investigation; or
(b) Resident elopement, if the elopement places the resident at risk of harm or injury.
(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.
(4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.
(6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident.

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A 165	Continued From page 2 The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review, staff interviews, and policy reviews, the facility failed to thoroughly investigate and report a resident elopement to the state agency for 1 of 1 sampled residents. (Resident #12) The findings include: A review of Resident #12's medical record revealed the resident was admitted to the facility on . A progress note, dated , indicating that, at 11:16 am, the nurse was called by the police station and informed that Resident # 12 was picked up in the Walmart parking lot by a police officer. The officer stated he was bringing the resident to the facility after the nurse	A 165		

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A 165	Continued From page 3	A 165		

confirmed she lived at facility. The police officer arrived to drop off the resident and stated the resident was ␣ in the Walmart parking lot and did not know her name or where she was. The police officer stated the staff were concerned as well because they saw her ␣ the parking lot and she appeared very . . . . . The resident was moved to the locked memory care unit until the family arrived. A review of the resident's health assessment (AHCA form 1823) dated revealed she had a diagnosis of with poor insight, was not oriented to time, recent memory abnormal, trouble driving, forgets conversations/dates, and had trouble remembering medications. The Walmart outing sign-up sheet dated revealed Resident #12 did sign for the outing to Walmart with facility staff.

A review of the Walton County sheriff's office incident report dated at 10:59 AM revealed the complainant was indeed Resident #12. The narrative described her as a white female elderly woman unsure of where she is at. Staff at Watercrest confirmed she was a resident, and she was returned to the facility and dropped off with staff. A review of the Google maps webpage conducted on at 8:40 AM revealed Walmart was 0.2 miles from the assisted living facility.

An interview was conducted with Employee C (a resident aide) on at 1:28 PM. Employee C stated Resident #12 was brought from Walmart by the police sometime in .

An interview was conducted with the facility's Administrator on at 12:55 PM. The Administrator stated she was on vacation at the time of the incident and she was not aware of

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A 165	Continued From page 4	A 165		

what occurred until just now. She stated Resident #12 should have had supervision while on the outing. She does not know the details of the incident. She stated the group of residents left the facility at approximately 10:30 AM on for the Walmart outing. The facility has a risk management program to investigate incidents like this. She verified the incident was not investigated or reported to the state agency. She stated the Health and Wellness Director would have been responsible for ensuring the incident was reported to the state agency and should have investigated while she was on vacation at the time of the incident.

An interview was conducted with the Health and Wellness Director (HWD) on at 1:17 PM. The HWD stated she reviewed Resident #12's health assessment when she moved in but did not recall seeing the diagnosis. She stated the resident's cognition fluctuated. She was not aware that the resident was going on the Walmart outing trip on . The HWD stated she had access to the state agency adverse incident reporting system and had been trained to recognize what is reportable.

Review of the facility policy for Missing Person Elopement (#1.52 revised) revealed the facility should submit a report to the state regulatory agency as per state regulatory guidelines. Make appropriate notations in the resident's record and update the resident service plan to reflect the incident, actions taken, and future interventions. Complete an incident report. The policy did not define elopement. Review of the facility policy for Resident Trips (#8.02 revised) revealed the facility staff should determine and plan for the number of associates and volunteers needed for each trip to ensure resident

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A 165	Continued From page 5 safety and enjoyment. Review of the facility policy for Investigating Accidents and Injuries (#5.05 revised) revealed the facility should investigate all accidents and injuries, witnessed and unwitnessed, that are incurred by a resident, associates, or visitor in order to determine cause, prevent recurrence, and initiate corrective and/or disciplinary action to associates. Class III	A 165		