STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911081	04/15/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Cities Pavilion	1053 John Sims Parkway Niceville, FL 32578	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

List of Tags Cited:
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= D

0000-Initial Comments
Compliant investigation CCR#2014002318 and 2014003389 was conducted - in conjuction with an Extended Congregate Care monitoring visit and follow up survey to CCR#2014000564 and 2014000992 and follow up survey to a Medicaid Program Integrity and Health Quality Assurance monitoring visit at Cities Pavilion Assisted Living Facility in Niceville, FL. Complaint allegations were not substantiated but related deficient practice was identified.

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC
Based on observation, record review and staff interview the facility failed to implement their elopement policy and procedures for 1 of 2 residents sampled for elopements (#7), failed to include provision in facility policy and procedures for at risk residents to have identification on their persons, and failed to conduct elopement drills in accordance with Florida Statutes.

The findings are:

Review of facility Adverse Event reports revealed documentation of a recent elopement for resident #7. The report described an elopement which occurred on at 3:00 PM when resident #7 could not be found within the facility. The report states staff had just begun a search of facility grounds when local police arrived to return the resident, who had been picked up "within 50 yards of the building". The report states the residents' wife had been informed prior to admission that the facility was not a locked facility and that she was notified after the elopement that the resident needs to be relocated due to the elopement risk he poses.

Review of facility policy "Resident Elopement" revealed an elopement is "an occurrence in which a resident leaves a facility without following facility policy and procedures". The policy states the facility does not maintain a secured unit. All potential residents shall be assessed prior to admission utilizing the "Brief Assessment" in conjunction with AHCA Form 1823 medical assessment. The policy is to screen all potential admissions for a history of wandering/elopement due to and to base admission on the ability of staff and the resident to maintain the safety of the resident. "Those with a history of wandering that cannot be controlled will not be admitted to the facility nor kept on a continued stay status." Residents identified as elopement risks will be required to be enrolled in "Project Lifesaver", which requires residents to wear a with a GPS tracking system. The policy states residents are to notify staff when leaving and are to sign in/out of a log. Facility staff responsibilities include maintaining behavior logs to identify/document wandering tendencies. Upon return to the facility, the resident's care plan will be revised to reflect the elopement and a prevention plan will be developed. The policy also includes a list of information to be provided to law enforcement in the event of a resident elopement, which includes a resident photograph.

Review of the "Brief Assessment" form for resident #7 dated (the day the resident was admitted for respite care) revealed documentation of "Very demented. Elopement risk." in the section for Behavior concerns. AHCA Form 1823 Resident Health Assessment documents a diagnosis of Late Stage and under the section titled "Special Precautions", is the statement "Wanders - walks, he will leave the building if not watched". The form is signed by the resident's physician, it is not dated.

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Observations of resident #7 on at 9:55 AM, 2:10 PM, and again on at 3:10 PM revealed no indication the resident was wearing any type of bracelet, anklet, , or any form of GPS tracking system.

Interview with the facility director on at 1:45 PM revealed her account of resident#7's elopement. She stated the resident did leave the building without staff knowledge but was found very close to facility grounds. She was asked if the resident actually left the facility property and she stated "Well, yes, but he was real close". She explained that local police found the resident just off the grounds across a small easement road between the facility and the adjacent Chamber of Commerce, at the back of the Chamber of Commerce building. She was asked if the resident is enrolled in Project Lifesaver prior to the elopement and she stated he was not, and that he is not actually a resident, but comes to the facility for respite care while his wife works. She was asked if he was enrolled in Project Lifesaver since the elopement and she stated he has not been enrolled as the wife and his case worker have been informed that he may not be appropriate for care here and they are supposed to be seeking other placement for him. She stated she did not want to burden the family with the expense of enrollment in the program if he is going to be leaving shortly.
Resident #7 was observed sitting in a chair in the front hallway on at 3:10 PM. The facility director was with this surveyor and was asked if the resident has any identification on his person. She, in turn, asked a nearby resident assistant, who responded "no, not that I know of,I've never seen anything on him with his name or any kind of ID". The facility director was asked to clarify an earlier statement that the resident only comes for respite care consisting of meals and necessary personal care, that he does not receive any medications at the facility. She confirmed, "No, he does not receive any med's here". She was asked if a Medication Observation Record (MOR) exists for the resident with any photo of him, she stated "no, we have no photos of him". During a continuation of this interview at approximately 3:20 PM, the director stated she realized about 2 weeks after the resident was admitted (prior to his elopement) that some staff were familiar with him and had worked with him at his previous day care/respite site and they alerted her that he had been an elopement risk there. She was asked what procedures she implemented once she became aware of this risk. She stated "I told the staff to keep a close watch on him". She confirmed she did not take any other measures at that time such as ensuring the resident had identification on him, or having a photo of the resident should it be needed in the event of an elopement, nor did she require the resident to be enrolled in Project Lifesaver. All of these measures (except the requirement for some form of identification) are called for in the facility elopement policy/procedure. She stated she was trying to do the family a favor by taking him, she then indicated that obviously it was a big mistake to do so. she stated this is the first person who has been accepted at the facility for respite care.

Review of facility elopement drills revealed documentation of an elopement drill conducted on at 9:25 AM on the swing shift. Only one staff member is identified by name as a participant. A second drill was conducted on at 11:15 PM on mid shift, again with only one staff member identified as a participant. Interview with the facility director on at approximately 3:45 PM revealed her method for conducting elopement drills is to set up a scenario, assign it to one shift who then enacts the scenario and discusses it during a scheduled staff meeting. She stated two of these drills are conducted annually. She acknowledged not all employees, nor all shifts participate in the actual drills, they are just present for discussion of the drills during staff meetings. She stated it is her understanding that this meets the regulatory requirement for elopement drills, and that not all staff have to physically participate in the drills. She also does not believe the drills need to be conducted on each shift, although each shift may differ regarding staffing levels and presence of administrative personnel.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Cities Pavilion
1053 John Sims Parkway
Niceville, FL 32578

Dear Administrator:

Re: CCR #2014002318, 2014003389

This letter reports the findings of a state licensure complaint survey that was conducted on , 2014 by representatives of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , 2014 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call me at 850-412-4540.

Sincerely,

Jonah Heiberg, M.S.W.
Field Office Manager

DH/pm
Enclosure
XG90

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