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	AL11911412	07/24/2015
NAME OF PROVIDER OR SUPPLIER **LIVEWELL AT COURTYARD PLAZA**	STREET ADDRESS, CITY, STATE, ZIP CODE **15520 NW 2 AVENUE** **NORTH MIAMI BEACH, FL 33160**	

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0000 Initial Comments

A Complaint (CCR#2015007433 & CCR# 2015004709) Survey was conducted from , 2015 to , 2015. Livewell At Courtyard Plaza with Limited Mental Health & Limited Nursing Services components had the following deficiencies identified at time of the survey .

0025 Resident Care - Supervision

Based on observation, record review, and interview, the facility failed to provide adequate supervision to meet the needs of 5 of 110 sampled residents who were assessed to be an elopement risk or residents that have a history of wandering from the facility. The facility failed to develop a plan of intervention to prevent imminent risk for serious injury or harm to 5 of 110 residents sampled.

Findings included:

Observation on at 9:00 am revealed that the facility has one point of entry. There is a lobby where only the receptionist at the front has access to open and close the main door. There is a sign in /out log for the facility's Residents. There was one locked exit door on the first floor and a locked emergency (exit) door upstairs. There is a census of 110 residents and 53 employees. The facility has non-functioning cameras in the entrance, back area and hallways.
Observation on at 12:00 pm revealed, that the second floor unit was divided into / and Independent living. However, the main entrance to the second floor area was opened allowing the five / Residents to walk in and out of the units, and two Residents taking the elevator to go to the first floor.
Record review on / for Residents with and elopement risk reveals the following information:
1. Resident #7 ' s AHCA Form 1823 (health assessment) states he is an elopement risk and requires redirection to not wander. Resident #7 needed supervision with all of his activities of daily living (ADL). Section 1 Part C- "In your professional opinion can this individual's needs can be met in an assisted living facility, which is not a medical, nursing or facility." is checked yes and with supervision.

Notes in Resident 7's Chart state, on " Resident left to appointment / and didn't show up back to facility. All elopement measures taken will continue to monitor, staff educated. "
2. Record review on / revealed, that Resident #1 was admitted on . The Resident's health assessment, dated on , assessed the resident with a history and diagnoses of , no physical limitations, or behavioral status as patient has difficulty attending to caring for himself and attending to his medical problems. Services requirements state that resident

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needs to be reminded to shower and change clothes. Resident #1 needs assistance for self -administration of medications. The Resident needs supervision ADL's; however, he is independent of ambulation and transferring. The Health Assessment states, Resident #1 requires reminders + encouragement to perform.

3. Record review on revealed, Resident #2 was admitted on /. The Resident ' s health assessment, dated on , is assessed with a history and diagnoses for , , High , and . Resident #2 ' s status was reflected as forgetful. Resident #2's health assessment was marked as no elopement risk, needs assistance with ADL's and independent eating. Resident #2 needed assistance with self - administration of medication.

4. Record review on revealed, Resident #3 was admitted on . Resident #3 ' s health assessment, dated on , assessed the resident with a history and diagnoses for , , High , and . Resident #3 ' s status is Forgetful and he requires services as assist with self -administration of medication. Resident #3 is marked as " yes " for an elopement risk. Resident #3 ' s ADL ' s reflects as independent and he has marked as " yes-to meet requirements to live in the facility. " Resident #3 needs assistance with self- administration of medication, as documented in the progress notes from to .

5. Record review on revealed, Resident #4 was admitted on . Resident #4's health assessment, dated / revealed a history and diagnoses for to , Left Femur Multiple Pelvic and , . Resident #4 ' s status is documented as severely , short-term Memory, limited insight, judgement and poor safety awareness. Resident #4 requires services as assist with self-administration of medication, and for elopement risk is marked as " yes "

6. Record review on / revealed, Resident #5 was admitted on /. Resident #5 ' s health assessment, dated on revealed, the diagnosis stated , with behavioral issues and . Resident #5 reflects sensory limitations as okay according to her age plus memory loss. Resident #5's as , precautions and needs supervision for her behavioral issues. Resident #5 is marked as " No " for elopement risk. Resident #5 ' s ADL's needs supervision, but she is independent with eating, ambulation and transferring.

7. Record review on / revealed, Resident #6 was admitted on /. Resident #6 ' s health assessment, dated on revealed, diagnosis stated and . Resident #6 has status as forgetful. Resident #6 has marked nursing requirements as assist with medication administration. Resident #6 has ADL's as independent, but he needs supervision on bathing and self-care ( ) as comments reflects as CNA Supervision. Resident #6 met needs to be at an assisted living facility and needs assistance with self-administration of medication.

8. Record review on / / of Facility Personnel files revealed the following information: Staff A hired on / had filed her Incident Report training on , Elopement Response training

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on and (and).
Staff B hired on had filed her Incident Report training on , Elopement Response training on and (and).
Staff C hired on had filed her Incident Report training on , Elopement Response training on and (and).
Staff D hired on had filed her Incident Report training on , Elopement Response training on and ( ).
Staff E hired on had filed her Incident Report training on , Elopement Response training on and (and).
Staff F hired on had filed her Incident Report training on , Elopement Response training on and ( ).
Staff G hired on had filed her Incident Report training was not in the file, Elopement Response training on and training was not in the file.
Staff H hired on had filed her Incident Report training on , Elopement Response training on and ( ).
Staff I hired on had filed her Incident Report training on , Elopement Response training on and (and).
Staff J hired on had filed her Incident Report training on , Elopement Response training on and ( ).
Staff K hired on had filed her Incident Report training not in file, Elopement Response training on and training was not in the file.
Staff L hired on had filed her Incident Report training on , Elopement Response training on and (and).
Staff M hired on had filed her Incident Report training was not in the file, Elopement Response training on and training was not in the file.
Staff N hired on had filed her Incident Report training was not in the file, Elopement Response training on and training was not in the file.
9. Record review on revealed, the last two Elopement drills were done on at 3:00 pm, and there was an Employee ' s elopement drill signed on . The other Elopement drill was on at 2:25 pm, and there was an Employee ' s elopement drill signed on .
Record review on revealed, the following information regarding Policy and Procedure for Resident ' s Elopement:
Livewell at Coral Plaza Policy and Procedure for Resident elopement, the definition is when a resident leaves the facility without following the facilities policy and procedure. Livewell at Courtyard Plaza is required that all residents or responsible party sign out when living the facility.
Operational Goal: The priority of this facility is to foster an environment of safety and good quality of life for all residents. Should a resident not sign out in the facilities Sign Out / Sign in Log Book (Temporary Log) indicating the date and reason for the temporary Absence, , nor communicate with the staff

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regarding his/her absence, it is therefore understood by the facility that the resident has left the facility without following the appropriate procedure. Although, the resident may travel independently within the community, the Assisted Living Staff is responsible for the whereabouts of the residents. When a resident is determined to be missing or their whereabouts unknown, the facility will make every attempt as quickly as possible to locate the resident.

Implementation: The following procedure will be followed when determined by the facility staff that a resident has eloped.

1- Any staff member who is unable to locate a resident after checking the " Sign Out" log book to verify the general whereabouts of that resident must immediately notify the Administrator or Designee, no matter what time of day it is.

2- If a resident is missing, all staff is notified immediately. They are given a description of the resident and details as to when and where the resident was last seen. They are also given a description of the clothing the resident was last seen in. The Medication Administration Record in the nursing station had pictures of each resident if needed.

3- Each Staff member is assigned an area to search. Areas include inside the building and grounds outside; Residents , Storage area, Stairwells, Hallways, Lobby, Public areas, Parking Lot, Parked Cars, Nearby Bus Benches / Any other possible pick up points.

The preliminary search efforts should not last more than 30 minutes from the time the resident was reported missing.

4- When the resident is found, that staff member must immediately report to the Administrator of the Designee to call off further search efforts.

5- After the resident is found the direct care staff in charge shall immediately conduct a though thorough observation, assessment of the resident. If findings reveal that the resident needs medical attention/ intervention, the resident's physician shall be contacted and orders follow. Call 911 if medical condition warrants more attention. If the missing resident is not discovered during the preliminary 30 minute search, the administrator must be notified immediately.

7- The Administrator or Designee will notify the police and the following information will be made available to them;

A) Description of Resident, Photo, Clothing worn
B) Physical and Mental capabilities and limitations
C) Address of prior residence and family residence
E) Descriptions of prior search efforts to this point
F) Family and or Responsible party contact information

8- All staff members shall cooperate with authorities involved with the investigation of the missing resident.

9- Family members and or Responsible party shall be notified by the Administrator or Designee after the 30 minutes search, the administrator must be notified immediately.

10- Within one (1) business day after the preliminary search and investigation of the Elopement, the

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ADVERSE INCIDENT REPORT " form faxed to the Agency's Adverse Incident reporting office as report on the adverse incident of the resident elopement / missing within 15 days of the date of adverse incident.
11- Any inquiries by news medical concerning the missing resident must be referred to the Administrator or Designee. No other staff member shall provide ANY information to the media.
Elopement Drills:
1- Effective , 2004 per 400.411 (1) (a) 3 F.S. All licensed Assisted Living Facilities shall conduct a minimum of two (2) elopement prevention and response drills. The elopement drills shall be conducted and consistent with the facilities resident elopement policy and procedure with total involvement by the Administrator and staff.
2- The elopement drill shall be documented on the prescribed form prepared by the facility after the individual conducting the drill completes the drill.
3- During the orientation of new hires and the annual in-service training of all staff, the administrator shall review the facility after the individual conducting the drill completes the drill.
4- On a bi annual basis, resident social director shall include the facility elopement policy and procedure to rehab residents.
5- Information for the following shall be documented on the " Elopement Drill Form";
a) Resident identification information
b) Resident status prior to elopement
c) Employees involved
d) Search actions
e) Results of search
f) Resident status when found
g) Employee response
h) Corrective actions as needed
i) Name and title of staff conducting the drill
10. Record review on the Signed In / Out log which states, " This ledger is for Responsible person to sign who are authorized to take a resident out of the Building.
***Please sign Out Properly Put your -Destination - Time you expect to return.
Also the signed sheet states : The below listed resident / responsible party accepts responsibility for said resident while away from the premises of this facility and absolves the management said the facility and its personnel for the responsibility for deterioration in condition or accident that may occur while the resident is away . It's understood that said amed resident that may occur while the resident will sign in upon their return, and remain in the facility or on the grounds until such time they sign out again.
The sign in /out log has the following information: Date on destination at library by self / time out at 10:00 am and no time in. On the same date, there is a time out at 1:22 pm by self-destination " work.".
"Record review on / to Resident #7 ' s Contract (signed on by Legal Guardian) reveals:

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Facility's Contract reflected that transportation is only provided for Assisted Living and Full Care Assisted Living. Independent residents are responsible for their own transportation to physician appointments. Independent residents are welcome to use the bus for all activity related events. There is no charge for activity related excursions.
Courtyard Plaza will take residents to physician appointments on Tuesdays and Thursdays. The Nursing Department MUST make the appointments. If there is an appointment on any other day, it is the responsibility of the resident and or family member to make arrangements to transport them to that appointment. All efforts will be made to assist you; however it may not always be possible.
Complimentary transportation to Physician offices needs to be within 10 miles radios from Livewell at Courtyard Plaza. Any appointments more than 10 miles and less than 20 miles, Livewell at Courtyard Plaza will help you arrange private transportation at your cost. Our employees are not allowed to transport residents in their own car nor are our employees allowed to use the Courtyard Plaza bus. For insurance and liability purposes our corporate policy states that only selected employees are permitted to drive the bus.
Courtyard Plaza transportation is a drop off, pick up service, we do make sure the resident get into the physician office, but we do not remain with the resident for the duration of the appointment. If you or your family member needs to be accompanied by an aide, there is an additional fee of $40.00 for the 1st hour and $20.00 each hour after that until they return to the building.
Also, if you or your family members are sent to the Emergency or any other appointment and needs to be brought back to Courtyard Plaza, again, we will make every effort to assist you, but it is the responsibility of you or your family member to make those arrangements. You will need to call a non-emergency transportation company or a cab to be brought back to Courtyard Plaza. Below is a list of companies you can call and make financial arrangements with them directly.

Review of Resident #7 Observation Log revealed:

" / .- Resident #7 schedule for a dr (doctor) appointment at local clinic. He hot pick up at 9:22 AM by transportation service. "

" .- I found out from Staff M that Resident #7 did not return to the facility from his apt (appointment). Staff M call local clinic to find out if he was report to the hospital. They confirm that he was a no show. Local law enforcement notified as well as the guardianship. Facility employee went out looking for him, but was unable to locate him. Local law enforcement put out a search for him. "

" / .- Check hospitals in area. He is not in any of the,. The detective and officer update that he has not been found " Facility staff went out with copies of photographs on file, giving it to the locals with contact information "

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" / - At 10AM call all area hospitals to confirm if Resident #7 has shown up there but he has hasn ' t. Facility staff went out with the photo and contact info looking for him "

" / -Front desk call hospitals and staff went out looking for residents in areas that we were told were hot posts "
" - Went back out look for resident with driver "

- Received call from detective that they have a missing person that fits description, for staff to come down and identify. Went down to medical examiner ' s office and confirm it was Resident #7 "

Interview on at 11:55 am with Staff O revealed, the following information: Staff M, the person responsible for the front desk, she trained me today in the morning; however, I have done it before ... I started to work at 8:30 am, I have to answer the phone, provide Residents money and make sure that they sign the log when they receive the money. The front desk staff are responsible for checking the resident that go out for appointments, transfer the phone and monitor those who have left the facility ... I do not know anything regarding any resident that has eloped from the facility recently; Staff A is the one who handles that. I am a Med-tech; I do the med-pass, and normally work 7-3 pm ... This is my first time covering the front desk; we do not have a list of resident that are elopement risk. We just notice if the resident wants to leave the facility. There are three Certified Nursing Assistants (CNAs) that work in on the third floor. The third floor is divided in two units, each unit has a CNA in charge and one will be floating on both units. The staff person was asked, do you know which resident is an elopement risk? No
Interview on with Staff B at 12:15 pm revealed the following information: Staff was a full time worker and she has been working in the facility for about five months. Staff B states she did not have any training regarding an elopement recently, and she also states that she does not know about any elopement recently at the facility. Staff B explained that she works at the memory unit, which stays closed at all times. Staff states, residents did not go with a companion to the physician's appointment.
Interview on / with Staff F at 12:20 pm revealed, she works full time, 7:00 AM to 3:00 pm, in the Memory unit. Staff F went on to say, she makes rounds every two hours to make sure that all the residents are in the unit. Staff states that the facility has had no elopement recently, and she has not had any recent training for elopement.
Interview on with Staff H at 1:25 pm stated, "I work everywhere but on Wednesday and Saturday I work in Memory unit. The CNA comes in the morning, knocks on the door and checks on the resident. If the resident is missing; we look at the book and check to see if they ' ve signed out. We walk all over the building looking for resident. If we don't find them we call Staff K, or Staff L to inform them the resident is missing. She calls Staff A and handle it. I was there when Resident #7 went missing. They said he had an appointment. He came in the dining area and someone told me he did not eat yet so they made him a sandwich. The bus came and took him to his appointment and he didn't come back. The

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staff member was asked, how did you know he was missing or when he was missing? Because I have to check every two hours to see if he is here. I know he went to an appointment but at the end of my shift he had not returned. The next day when I came in, at seven in the morning, they were asking, where is Resident #7. They said, " I don't know " because they did not know. Sometimes we have a meeting at 8:30 AM to 9:00 AM in the morning.

Interview on / / at 1:00 pm with C stated, " My Memory residents are Resident ' s # 4 and 8, I know who they are just by giving medications daily. I don't know for sure who elopement risks are; I heard Resident #7 walked away from the facility. I heard he went to a doctor's appointment at the local hospital and did not return to the facility that day. The front desk has a book that has the dates when residents have appointments. A couple of days ago they found out that Resident #7

Interview on at 1:52 with Staff K at 1:52 pm, the staff member reported, - I know Resident #7 went out to a doctor's appointment that morning and after the doctor's appointment, the residents usually take forever to return. They take time to see them. Some return to the facility around 3:00 pm to 4:00 pm. Some are not back until 6:00 pm to 10:00 pm. Sometimes they keep them over night. The CNA had him and brought him to the appointment. They save the food for him. When I came in the next morning, Staff L, she was telling me about the page (contact between staff) that he was not at the facility. She had front desk call the hospital. We (Staff A & L). We went out to look for him on the facility bus to check. The front desk called all the hospitals. We called the police and made a report. I stayed behind when they got back. We printed pictures and went out again. Staff A and I went out, then Staff L and I went out. Staff M was working the front desk when he left. No one went out with him. We talked to the officer and called in the detective. We went out again and he met us out in North Dade to sign some paper works. After the incident, we had meetings, regular meetings with CNA and covered the policies and procedures for elopement for the 7Am to 3Pm shift. We informed them (the staff) he had left and did have not come back. We review elopements, two hours checks, to look for residents if we don ' t know where they are. We met with the CNA's at 4:00 pm and informed them of the same thing. I called for a meeting for the 11:00 pm to 7:00 am shifts and told them what happened. No one else has gone looking for him. He has no family. We called the guardianship and after the police came. Staff A filed an adverse incident. We documented from the time he left. On / / , the Detective called and said, we have a black male that fits the description. Between 9:30 am to 11 am, he asked us to come down to the coroner ' s office. Staff L & I went down to identify him. After we received a call from the detective. We wrote Staff M up, had a meeting with her, since then she hasn't returned and has been calling in sick. A new person is going to start soon. We did training on elopements verbally, re-education but (no sign in sheet was completed), and two hour checks. She was written up because she knew who was supposed to leave with a companion.

Interview on at 4:36 pm with Staff J stated, "I have been here almost two years. I have all my trainings. An elopement is when a resident is missing, they had assessments. They are assigned to A, B, or first floor. First thing in the morning we check the . If we don't see them then we talk to other coworkers. Everyone stops working and checks outside and inside. If we don't see the resident we

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advise the supervisor who advises the administrator. There have been no elopements recently. We don't have those things frequently. In the meeting we talked about Resident #7. We usually have a meeting everyday around 4:00 pm or 4:15 pm. there are three people (Residents # 3, 4 and 7) who need to be accompanied by someone. We are supposed to send an aide for with Resident #4 and 7. Resident #3 is supposed to go with her husband. Resident #4 has and is currently upstairs in the dining . I was not assigned on the first floor. Resident #7 went to an appointment. Sometimes the residents come back after five.I know that was on a Tuesday. Sometime I don't know when he goes to his appointment. I don't know when they realized he went missing because my shift is 3PM to 11PM. We told the manager on duty and the Med-tech on duty. I don't know; if someone calls to confirm, if the resident arrived to the destination on time. I have never escorted anyone.
Interview with the Transportation Coordinator Supervisor on / / at 2:30 pm stated, " Resident #7 was picked up from Livewell At Court Yard Plaza at 9:30 am and dropped at the local clinic ' s door at 10:22 am. There was no aide from the facility with him. "
Interview with the local clinic receptionist on / a 9:00 AM via phone stated, Resident #7 was a no show. It would have been the first time seeing this resident.
Interview via phone on / at 12:51 pm with Resident #7 Guardians it was stated, "He came to us unfunded. We found out his real name and he has family, a daughter who is out of the country. We spoke to the granddaughter. Livewell contact us and informed us to tell us they filed a missing persons report on when he went missing since . On they called to tell us that Resident #7 had been hit by a car and . Staff K told our co-worker that the receptionist buzzed him out by mistake. Apparently they told us they fired her and replaced her with someone else."

Record review on / revealed, that there was a signed documentation in the facility named ""Disciplinary Action Form " dated on / . The documentation was on behalf of Staff N, which indicates that it was a written notice at 10:00 am.

Record review on revealed, that the Disciplinary Action Form indicates, " Nature of Incident or Complaint Staff M failed to follow the proper procedure allowing a Resident to leave the facility unsupervised, knowing he had to have a companion. This was told to her by her supervisor and the Staff N. "

Record review on revealed, the Disciplinary Action Form also indicates, " Employee Response; Staff M response was that she forgot, and realized she messed up.

Interview on at 9:50 AM Staff L stated, " I was preparing to do my rounds and then she (Staff M) paged on the at 7 in the morning asking for Resident #7. "
Interview on at 10:00 AM with Staff K stated, " The 7:00 AM to 3:00 PM shift have daily

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meetings at 2:30 PM to discuss any concerns with the resident. The 3:00 PM to 11:00 PM shift, does their rounds and we have a meeting at 4:00 PM. So then they put in their reports at 11:00 PM, they know if anything has happened to the residents.
" Usually, if someone is out, they do call. But because they know they go to the local hospital, they have been so branded and so lax thinking that it is okay when the resident does not return. Thinking he just went to the hospital. "
The clinic closes at 5:00 pm.
" Even if they go to the clinic at 5:00 pm they get sent to the local hospital. Because I've had one resident that ' s had difficulty breathing sent straight from the clinic to the local hospital;. I called and luckily the Resident had a cell phone, and they had my cell phone number. He called me on the way and said he is being transferred. So, I was like okay.

Interview on at 9:35 am revealed, that the Administrator stated, " Staff G did not follow the Facility ' s procedure and policy. This was not the first time she made an appointment for a Resident; she knows that there is a list, which indicates the residents that need to be escorted. Staff G knew that Resident #7 had an appointment and he was there twice. Staff G was responsible for making all resident appointments, send the Resident to the appointment and follow the appointment. We have residents that stay late (10:00 pm); however, in that case the CNA ' s will be in charge to follow the resident ' s appointment.

Interview on at 9:44 am with the Staff A and K it was stated, " We assess the Residents that need escort to go to their appointment by their health assessment (Form 1823). Staff K creates a list with the names of the Residents that are in an elopement risk. The Staffs A and K stated, " Staff F and H are the escorts and they stay with the Residents until the appointment is finished. "

Interview on at 10:00 am with Staff K it was stated, " Resident #7 left from the facility in the morning around 9:00 am with the transportation, and no escort. She find out that Resident #7 did not show to the doctor ' s appointment and did not return to the facility the next day. "

Interview on at 10:49 am with Staff H it was stated, " I assisted Resident #7 to get ready, and I took him to the Lobby with Staff M. I was to busy to stay; therefore, I did not know who escorted him. However, we did not have an escort that day ( ); we were very busy that day. The person working at the front desk is responsible to follow up with the Residents ' appointments, 'I signed in the two hours log that he was out because he was not at the facility; I knew he went to the hospital. I continued my observations every two hours. At the end of my shift, I went to the front and Staff N stated, that Resident #7 was still at the hospital. I communicated to the afternoon CNA that Resident #7 was at the hospital. We have a meeting every day at 3:00 pm, where we report what happened during work time; however, nobody stated that Resident #7 did not show to the hospital or that he did not come back from the

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hospital; therefore, I left my work assuming that he was still at the hospital; it is normal for us to to have a Resident come back late from the hospital or stay there. We do not have meetings during the morning time, we have the meetings at 3:00 pm. I did my rounds early in the morning, and I did not see Resident #7 in his , but I assumed that he was hospitalized; I did not know that he was missing. Around 10:00 am someone told me that Resident #7 was missing. However, I continued working, I do not have to do nothing else; the Administration was in charge of the incident. "

Interview on at 11:26 am with Staff F it was stated, " We do not have meetings at in the morning time, we only have them change of shift. We have our meetings at 2:30 pm, I have worked as an escort, but I had never escorted Resident #7; however, we have no escort on Mondays. " Staff F stated, " normally Staff L called the person who will escort the Resident; I have gone with Resident #4 to Doctor ' s appointment; on the meeting was a normal meeting, they just mention that Resident #7 was missing. We did not have any training from that day on (/).

Interview on at 11:55 am with Staff L it was stated, " We did not have a floater working on / "

Interview on at 11:59 am reveled, Staff G stated, " I put her initials and circulated them to indicate that Resident #7 was out of the facility, and not taking his medications. At the beginning of my shift; It was reported that Resident #7 was at the hospital; however, at the end of my shift, I assumed that he was still in the hospital. I made my daily report, which I indicated the Residents ' status as medications given or not given. For Resident #7, I put that he was out of the facility. There is a box for the where Staff K, and I put my report inside. When I came back on Tuesday ( ), there was a meeting at 3:00 pm, and they (Staffs K and L) explained that Resident #7 went to the Hospital, but he did not come back. Staff G stated, " We did not have an elopement ' s training; it was a general meeting, and they explained that Resident #7 did not come back from the facility. "

Class I

0077 Staffing Standards - Administrators

Based on record review and interview the facility failed to ensure the Administrator have a a high school diploma or G.E.D.

Findings include:

Internet search done on / of facility finder indicates Staff A as the Administrator.

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Record review of Staff A (hired /) had no proof of high school diploma in her personnel file.

Interview with the Administrator on at 4:15 PM stated, "I have one. I don't have a copy here."

Class III

0078 Staffing Standards - Staff

Based on record review and interview the facility failed to ensure qualified staff have proof of a negative examination documented on an annual basis for two out of fourteen (#E and G).

Findings included:

Record review found that Staff E (hired), and Staff G (hired / did not have a proof of a negative examination documented on an annual basis. The last written statements shows communicable statement for Staff E dated / and for Staff G dated / . There was results for documented.

Interview on / at 4:15 PM the Administrator stated, " Everyone is suppose to have it."

Class III

0089 /Other - Special Care

Based on record review and interview the facility failed to ensure four out of fourteen (#G, K, M, and N) sampled staff who is employed by a facility that provides special care for residents with 's or other related , and who has regular contact with such residents, must complete up to 4 hours of initial -specific training developed or approved by the department.

Findings included:

Record review of the employee files for fourteen staff members sampled found STaff G, K, M, and N does not have the Alzhiemers training. Staff A, C, D, E, F, I, J, were not retrained in Alzhiemers after incident where resident eloped on / .
During the interview it was revealed the resident had and required an escort to all appointments outside of the facility. There is no documented escort policy per the facility but it is addressed in the transportation amendment of the resident ' s contract. All doctor appointments are scheduled for Tuesday and Thursday and those needing supervision, the service will be provided by the

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facility for an additional fee. The staff will ensure the resident makes it to the doctor office and return to the facility.

Resident #7 appointment was scheduled for Monday . Per interview with the Transportation service, the resident was picked up from the facility at 9:30 AM and dropped off at Clinic. There was no call for a return pick up for the resident.
Interview with staff from Clinic on / at 9:00 am confirmed Resident #7 had an appointment but was a no show. This would have been Resident #7's first visit to the facility.

During the investigation, it was determined the facility did not follow their own " unwritten " policy for resident needing to be escorted to all appointments. The facility was under the impression the resident went to Medical Center and not the Clinic, stating resident typically doctor appointments take very long and in some instances residents are kept overnight. Never realizing the resident was no sent to the hospital but an offsite clinic of the hospital.

The staff member who is in charge of ensuring the resident sign in and out and making sure the residents are escorted as needed, has not returned to work since the incident and has not answered multiple calls from the agency. The new staff trained to replace her was unaware of residents who are elopement risk and required an escort.

Interviews with multiple staff found they had not been aware of the residents who are an elopement risk and denied receiving the additional training as stated by the Director of Nursing (DON) during interview.

All staff members ' interviewed could not accurately explain the facility ' s elopement policy and procedure.

The facility currently has five residents with / , three residents who are an elopement risk and two resident needing an escort.

Class III

0165 Risk Mamt & QA: Adverse Incident Report

Based on record review and staff interview the facility failed to complete and submit 1 day initial adverse incident report and 15 day full incident report to the agency for one out of seven (#7) sampled residents.

Findings included:

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On Resident #7 left the facility via transportation. On it was determined the resident never returned to the facility (the police were notified). On the resident was hit by car on 14 miles away from the facility on a busy highway (without some knowing from the facility). On the facility was notified of a John Doe that matched the description of the resident and was summoned to the Medical Examiner ' s Office to identify his body.

Resident record review for Resident #7 was admitted to the facility on . The Health Assessment dated indicated the resident was diagnosed with as well as an elopement risk.

There are currently five residents with at the facility with three being an elopement risk. The facility currently has two residents who require escorts as deemed by the facility. Resident #7 is an elopement risk and requires redirection to not wander. He needs supervision with all of his activities of daily living. The assessment states he does not needs 24 hour nursing or care states he needs supervision. In the section where "In your professional opinion can this individual's need be meeting in an assisted living facility, which is not a medical, nursing or facility." It ' s check yes and with supervision.
Notes in Resident's Chart written by the Nurse Manager state, on " Resident left to appointment and didn't show up back to facility. All elopement measures taken will continue to monitor, staff educated. "
The last two Elopement drills were done on / / at 3:00 PM, and / / at 2:25 PM.
Record review of the facility Elopement ' s policy and procedures reveals the following information under Implementation: The following procedure will be followed when determined by the facility staff that a resident has eloped.
1- Any staff member who is unable to locate a resident after checking the " Sign Out" log book to verify the general whereabouts of that resident must immediately notify the Administrator or Designee, no matter what time of day it is.
2- If a resident is missing, all staff is notified immediately. They are given a description of the resident and details as to when and where the resident was last seen. They are also given a description of the clothing the resident was last seen in. The Medication Administration Record in the nursing station had pictures of each resident if needed.
3- Each Staff member is assigned an area to search. Areas include inside the building and grounds outside; Residents , Storage area, Stairwells, Hallways, Lobby, Public areas, Parking Lot , Parked Cars, Nearby Bus Beeches / Any other possible pick up points.
The preliminary search efforts should not last more than 30 minutes from the time the resident was reported missing.
4- When the resident is found, that staff member must immediately report to the Administrator of the Designee to call off further search efforts.
5- After the resident is found the direct care staff in charge shall immediately conduct a though

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observation, assessment of the resident. If findings reveal that the resident needs medical attention/ intervention, the resident's physician shall be contacted and orders follow. Call 911 if medical condition warrants more attention. If the missing resident is not discovered during the preliminary 30 minute search, the administrator must be notified immediately.
7- The Administrator or Designee will notify the police and the following information will be made available to them;
A) Description of Resident, Photo, Clothing worn
B) Physical and Mental capabilities and limitations
C) Address of prior residence and family residence
E) Descriptions of prior search efforts to this point
F) Family and or Responsible party contact information
8- All staff members shall cooperate with authorities involved with the investigation of the missing resident.
9- Family members and or Responsible party shall be notified by the Administrator or Designee after the 30 minutes search, the administrator must be notified immediately.
10- Within one (1) business day after the preliminary search and investigation of the Elopement, the ADVERSE INCIDENT REPORT " form faxed to the Agency's Adverse Incident reporting office as report on the adverse incident of the resident elopement / missing within 15 days of the date of adverse incident.
11- Any inquiries by news medical concerning the missing resident must be referred to the Administrator or Designee. No other staff member shall provide ANY information to the media.
Record review to the facility ' s Incident Report reveals the following information:
Record review to the facility ' s Incident Report reveals the facility had sent two Incident Reports to the Agency for Healthcare Administration. There is (one day) incident report dated on and the 15 day incident report dated on / . The second incident report (one day report) dated on and the 15 day report dated on . Therefore, there are no more incidents reports reflected on the report printed on / in regards to resident who left the facility and did not return.

Interview with the Adminstrator on at 5:00 PM stated, she did the adverse incident report to AHCA and could not verify it was submitted.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2015

Administrator
Livewell At Courtyard Plaza
15520 Nw 2 Avenue
North Miami Beach, FL 33160

RE: CCR #2015004709 & 2015007433

Dear Administrator:

This letter reports the findings of a Complaint Inspection Survey that was conducted on [redacted], 2015 by representative(s) 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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than [redacted], 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 surveyor(s). Should you have any questions please call Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure
XG90

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8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Livewell At Courtyard Plaza
15520 NW 2 Avenue
North Miami Beach, FL 33160

Dear Administrator:

This letter reports the findings of a complaint 2015007433 inspection survey conducted on 16-24. 2015, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) by , 2015

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervision S-S= Class I
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= Class III
St - A - 0089 - 429.178 Fs - /other - Special Care S-S= Class III
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= Class III

Directed Corrective Actions:

1. The Assisted Living Facility is required shall create and implement a new elopement/ missing person policy and procedure. The policy must contain, at a minimum, specific conditions and timeframes indicating when a resident absence is considered an elopement, specific timeframes for notifying law enforcement and family/ responsible party, and specific requirements for staff on tasks and documentation. Documentation verifying all staff (current staff and future staff) be trained in this policy must be kept on file at the facility, and available for agency review by /
2. The Assisted Living Facility is required to document any and all known whereabouts of all residents per shift in addition to the facility's Form which would completed every 2 hours. The Form should be initialed by the staff member completing the assessment along with a key documenting the staff initial in comparison to their full name. Review of the form should take place every shift by nursing staff as well as the Director of Nursing and Administrator. Documentation of this review should be maintained to agency review.
3. The Assisted Living Facility is required shall create and implement a policy on providing supervision to all residents with / or exhibiting wandering/elopement behaviors. The policy should include a procedure for those residents who are unable to Sign In and Out of the facility as well as those needing additional supervision due to altered status. Documentation verifying all staff (current staff and future staff) be trained in

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this policy must be kept on file at the facility, and available for agency review by

4. The Assisted Living Facility is required to create and implement a policy insuring all adverse incidents are reported to the agency including elopements that may place the resident at risk of hard and injury. All staff must be trained on the policy within ten business days
5. The Assisted Living Facility is required to ensure all residents as well as those who exhibit wandering or elopement behavior has their photo placed at the receptionist desk alongside the facility's Sign In/Out Sheet. Those residents who are unable to sign themselves out should follow the facility supervision policy.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact Laura Manville, Survey and Certification Support Branch, at (727) 552-1955 Kristal Branton, 11 Miami, 305-593-3100

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb

D7JR

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