STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965554	C

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDHILL GARDENS RETIREMENT CENTER	24949 SANDHILL BLVD PUNTA GORDA, FL 33983

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

0000 Initial Comments

An unannounced complaint investigation CCR #2016001043 was conducted on / / through / / in conjunction with the Biennial survey at Sandhill Gardens, an Assisted Living Facility located in Punta Gorda, Florida.

There was one allegation in this complaint which was substantiated with a class 1 deficiency cited at A0025; a class 2 deficiency cited at A0010; and class 3 deficiencies cited at A0008, A0032, and A0165.

0008 Admissions - Health Assessment

Based on a record review and interview, the facility failed to ensure there was a new health assessment performed for 1 (Resident #13) of 1 resident upon admission due to a change in condition.

The findings included:

The documentation in Resident #13's observation log showed on / , the resident was moved from independent living (unlicensed area) to assisted living as the resident was [redacted] at times, "thinking she has to leave and needs closer monitoring..."

A review of the Resident #13's health assessment revealed it was performed on at admission to the unlicensed independent living part of this facility. The transfer to the assisted living facility was 66 days after the health assessment was completed. There was no new health assessment obtained after this transfer.

It was confirmed with the Chief Operating Officer on / at 4:45 p.m. there was no health assessment performed for this resident at the time the admission to assisted living was done.

Class III

0010 Admissions - Continued Residency

Based on a review of policy and procedure, review of resident and police records, and staff interview, the administrator failed to ensure the continued appropriateness for 1 (Resident #13) of 2 residents reviewed. This failure to ensure the facility could meet the needs of an eloping resident contributed to the [redacted] of the resident.

The findings included:

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SUMMARY STATEMENT OF DEFICIENCIES
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Resident record review revealed Resident #13 was admitted to the Assisted Living Facility (ALF) on . Prior to moving into the ALF, this resident lived in the independent living area that is non-licensed. The documentation in the resident observation log stated the resident was moved from independent living to assisted living because "she is at times, thinking she has to leave and needs closer monitoring..."
A health assessment was done at admission to the independent living area on . This was the only health assessment available for review. On the health assessment the physician had checked the resident was not a risk for elopement.

The resident observation log revealed on , the resident had eloped from the facility and was returned by the sheriff's department. The documentation in the resident's record discussed the resident's elopement issue and recommended the resident be transferred to a locked unit. At that time, it was also "suggested" to the resident's family that she be fitted with a Project Lifesaver wristband (geographic positioning device).

A police report dated at 7:15 p.m. said an officer was dispatched to an address in Punta Gorda. The officer indicated Resident #13 was sitting on the home owner's front porch. The resident explained to the police officer that she had walked from the building where she had been living as she had "a fear that somebody was in her ." The officer brought the resident back to the ALF and turned her over to staff who were waiting for her. There was no documentation in the resident's record about this incident.
On at 10:30 a.m., the Administrator revealed she was unaware of this elopement from the facility, and she agreed she had no documentation about this incident.

A review of the police report for the incident on documented at 6:00 p.m., the DOO was leaving the facility through a security door by using the security code, Resident #13 "followed him out the door." The DOO told the officer, the resident was claiming her neighbor's child "has been abducted." The resident was escorted back into the facility and was sat in the dining "another facility staff member."
The police report notes the police officer reviewed the facility's security camera system. This revealed the camera is motion sensitive. According to the camera date and time at 6:05 p.m., the resident was shown going to the door, moving to the key by the door and pushing buttons and going back to the door. The security footage showed an empty doorway and someone was standing on the other side of the door. (On at 10:30 a.m., survey staff observed the same security footage.)
The police report continues to say, "The staff on duty contacted [the DOO] and other administrators of the missing person. [The DOO] returned to the facility...One of the employees who had entered just after [resident name] was at the door (6:05 pm security footage) told [DOO] that he did observe [resident

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
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name] outside the door in the parking lot."

A review of the facility policy and procedure for elopement stated any resident who elopes from the facility will be given a 45 day notice.

On __/__, at 12:00 p.m., the administrator said she did not give notice as she wanted to give the family an opportunity to look at locked units. She agreed there was no further follow-up with the family when they determined the resident required another type of facility.

On __/__ at 2:27 p.m., the family member of Resident #13 said she had met with the DOO, Administrator, and Caregiver Supervisor after the resident had eloped in _____. She said they discussed moving the resident to a secured unit in another facility and also discussed Project Lifesaver. This family member said the main time the resident was agitated and trying to leave was after supper and before bedtime. She said she later spoke with the Caregiver Supervisor who agreed it would be more for the resident to move and it would not be necessary to move the resident. The Caregiver Supervisor told her the facility would increase staff and check the resident every 1/2 hour and there should not be any problem. The family member said after that conversation with the Caregiver Supervisor she did not consider moving the resident any longer. She said she had no further conversations with either the Administrator or the DOO. She said she had gotten the information about Project Lifesaver from the Caregiver Supervisor a few weeks ago. She said she was going to speak to her brother about it, as he is the Power of Attorney and handles the resident's funds.

Class II

0025 Resident Care - Supervision

Based on record review, interviews with both administrative and care staff, and review of police reports, the facility failed to ensure sufficient supervision to prevent elopement for 1 (Resident #13) of 1 resident. Failure to provide sufficient supervision resulted in the of the resident and has a potential to affect any other resident with exit seeking behaviors.

The findings included:

Record review revealed Resident #13 was admitted to the Assisted Living Facility (ALF) on __/__/__. The documentation in the resident observation log stated the resident was moved from independent living to assisted living because "she is at times, thinking she has to leave and needs closer monitoring..."

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SUMMARY STATEMENT OF DEFICIENCIES
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On / /, the Resident Observation Log further documented, "Approximately around 7 p.m. staff noticed [the resident] was not in her . Staff searched the facility immediately and were about to notify management when the Sheriffs officer came tot he facility entrance with [the resident]. Stated they found her around the corner on Deep Creek Blvd. Stating she was going to her sister's house and brought her back to the facility. Her sister was called and notified of this event. Her sister came to the facility and met with management to discuss what had occurred." During the meeting, it was recommended the resident be moved to a locked facility, and the resident would benefit from a "Project Lifesaver" wristband. (Project Lifesaver is a tracking device for people who wander that allows the resident to be tracked to their location).
Continued review of the resident record revealed on / /, there was a note indicating the family did not want to move the resident. On / /, the resident went to the physician and had medication adjustments. The resident's medication (use to treat behavior symptoms associated with in the elderly) was increased to 0.25 mg 3 times a day at 8:00 a.m., 3:00 p.m. and 8:00 p.m.

Review of the facility policy and procedure related to elopements revealed the following information: elopement was defined as any resident who leaves the facility property without staff knowledge and is unable to find their way back without assistance. The policy then goes on to state any resident who elopes from the facility will be given a 45 day notice to relocate. The policy also describes the procedure related to what happens and the steps to take when a resident is missing.

On / at 12:00 p.m., the Administrator confirmed the resident was not given a 45 day notice as per the facility's policy. She said she wanted to give the family an opportunity to visit the locked unit at their sister facility. She agreed she did not follow-up about project lifesaver for this resident.

On / / at 1:24 p.m., an interview with the Project lifesaver coordinator for Charlotte County Sheriff's department revealed the average lost time for a person with wrist in place is 30 minutes from the time of report.

A police report dated / / at 7:15 p.m. said an officer was dispatched to an address in Punta Gorda. The officer indicated Resident #13 was sitting on the home owner's front porch. The resident explained to the police officer that she had walked from the building where she had been living as she had "a fear that somebody was in her ." The officer brought the resident back to the ALF and turned her over to staff who were waiting for her. There was no documentation in the resident's record about this incident. On at 10:30 a.m., the Administrator revealed she was unaware of this elopement from the facility, and she agreed she had no documentation about this incident.

On / , there were physician's orders to change the to "0.5 mg daily in the evening for

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SUMMARY STATEMENT OF DEFICIENCIES
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agitation" as the facility contacted the physician about the patient being in the evening. is a drug used to treat and .

On /_ _, the Resident Observation Log documented at 6:45 p.m., the Director of Operations (DOO) was notified the resident was missing. The facility followed their policy and searched the building and the surrounding environment and the resident remained missing. The sheriff's department was notified at approximately 8:05 p.m. and an amber alert was issued. The facility and police searched for the resident. (The weather on /_ _/_ and /_ _/_ was and rainy throughout the night.) The resident was found on / at approximately 8:30 a.m. in the grass by the road between Sandhill and Deep Creek Boulevards. The resident was when found.

Both the Administrator on / / at 1:10 p.m. and the Chief Operating Officer on / at 9:30 a.m. described Resident #13 as being more restless and after going out with family. They stated the resident had gone out with family on / / .

A review of the police report for the incident on /_ _/ documented at 6:00 p.m., the DOO was leaving the facility through a security door by using the security code, Resident #13 "followed him out the door." The DOO told the officer, the resident was claiming her neighbor's child "has been abducted." The resident was escorted back into the facility and was sat in the dining "another facility staff member."
The police report notes the police officer reviewed the facility's security camera system. This revealed the camera is motion sensitive. According to the camera date and time at 6:05 p.m., the resident was shown going to the door, moving to the key by the door and pushing buttons and going back to the door. The security footage showed an empty doorway and someone was standing on the other side of the door. (On / at 10:30 a.m., survey staff observed the same security footage.)
The police report continues to say, "The staff on duty contacted [the DOO] and other administrators of the missing person. [The DOO] returned to the facility...One of the employees who had entered just after [resident name] was at the door (6:05 pm security footage) told [DOO] that he did observe [resident name] outside the door in the parking lot."

On _ _/ _ at 4:45 p.m., the Chief of Operation said they did not have any camera tapes of the part of the incident when the resident followed the DOO out the secured employee door.

On _ _/ _ at 1:13 p.m., Staff J, who was in the dining the DOO brought the resident back to the facility, stated he was cleaning the dining . He said he has no responsibilities for resident care or supervision; he is in and out of the dining . He said, "I know I saw the DOO bring her back, but I didn't really hear what he was saying about the resident." He further stated he saw the resident searching in her purse, but could not say what time it was when he last saw the resident.

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On at 2:23 p.m., Staff H, who was assigned to care for the resident that evening, indicated she was unaware the resident had exit seeking behavior earlier that evening. She said she last saw the resident at about 5:45 p.m. She said she started looking for the resident between 6:30 p.m. and 6:45 p.m. and was unable to find her.

On at 2:27 p.m., the family member of Resident #13 said she had met with the DOO, Administrator, and Caregiver Supervisor after the resident had eloped in . She said they discussed moving the resident to a secured unit in another facility and also discussed Project Lifesaver. This family member said the main time the resident was agitated and trying to leave was after supper and before bedtime. She said she later spoke with the Caregiver Supervisor who agreed it would be more for the resident to move and it would not be necessary to move the resident. The Caregiver Supervisor told her the facility would increase staff and check the resident every 1/2 hour and there should not be any problem. The family member said after that conversation with the Caregiver Supervisor she did not consider moving the resident any longer. She said she had no further conversations with either the Administrator or the DOO. She said she had gotten the information about Project Lifesaver from the Caregiver Supervisor a few weeks ago. She said she was going to speak to her brother about it, as he is the Power of Attorney and handles the resident's funds.

Class I

0032 Resident Care - Elopement Standards

Based on record review and staff interview, the facility failed to ensure all direct care and administrative staff participated in two elopement drills per year for 13 (Staff C, E, F, H, M, N, O, P, Q, , , U, and V) of 18 staff reviewed.

The findings included:

On at 10:30 a.m. a review of the elopement drill conducted on revealed that 10 (Staff E, F, H, M, N, P, Q, , , U) of 18 direct care staff did not attend the elopement drill. A review of the elopement drill conducted on revealed that 10 (Staff C, E, F, M, N, O, P, Q, U, V) of 18 direct care staff did not attend the elopement drill.

On at 11:00 a.m. the administrator said she had documentation for the above two drills. She said other elopement drills were held on other shifts. No documented evidence was provided to substantiate further training.

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Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on a review of the resident records, police reports, and adverse incident reports submitted by the facility, the facility failed to ensure 2 of 3 adverse incident reports were filed for Resident #13.

The findings included:

A review of Resident #13's resident record revealed the resident eloped from the facility and was returned by the police on / / .

A police record dated / / stated Resident #13 was again returned to the facility after eloping.

There were no adverse incident reports, either the initial or the 15 day reports, filed for either of the incidents.

On / at 11:30 a.m. this was confirmed by review of the Agency for Health Care Administration web site which contains adverse incident reports. The only report filled was for the elopement incident of / / .

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Sandhill Gardens Retirement Center
24949 Sandhill Blvd
Punta Gorda, FL 33983

Dear Administrator:

This letter reports the findings of a complaint, CCR# 2016001043, inspection survey conducted , 2016 through , 2016 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) within **five business days** of receipt of this hand delivered report.

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

St - A - 0008 - 429.26(4-6) FS; 58a-5.0181(2) Fac- Admissions - Health Assessment, Class III
St - A - 0010 - 429.26(1&9) FS; 58a-5.0181(4) Fac- Admissions - Continued Residency, Class II
St - A - 0025 - 429.26(7) FS; 58a-5.0182(1) Fac- Resident Care - Supervision Class I
St - A - 0032 - 58a-5.0182(8) Fac- Resident Care - Elopement Standards Class III
St - A - 0165 - 429.23(1-4 & 6-10) FS; 58a-5.0241 Fac- Risk Mgmt & Qa; Adverse Incident Report, Class III

Directed Corrective Actions:

1. Within 48 hours, a Registered Nurse who is familiar with the Florida Assisted Living Facility rules and regulations will conduct an elopement risk assessment, as well as a continued residency requirements assessment (based on the facility's ability to meet resident planned and unplanned needs) for all residents in the Assisted Living Facility. The facility will refer any resident to their Health Care Provider if their health condition status has changed since their last Health Assessment was performed. Documentation of these assessments must be maintained in each resident's file.

2. The Assisted Living Facility administration will review and revise the facility 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 all staff on tasks and documentation. This will be completed by the Assisted Living Facility Administrator no later than , 2016.

3. All Assisted Living Facility staff will be trained on the elopement procedures and will participate in elopement drills. These drills will be conducted on all shifts. This training and these elopement drills will be completed by no later than , 2016. Documentation of the training and elopement drills, including content and sign-sheets must be available at any time for review by the Agency upon request.

4. The Assisted Living Facility administration will develop policies and procedures on documentation which include at a minimum: requirements for all staff to document resident behaviors, changes in condition, as well as other factors that affect resident care and supervision when they become aware of these situations. This policy will include who is responsible for continued review of this documentation, what actions will be taken by the facility as a result of this documentation, what staff is responsible for these actions, and procedures for communicating this information to all staff. This will be completed by the Assisted Living Facility Administrator no later than , 2016.

5. All Assisted Living Facility staff will be trained on the above documentation policy and procedures. This will include training for all staff on documentation of resident behaviors, changes in condition, as well as other factors that affect resident care and supervision. This training will be completed by no later than , 2016. Documentation of the training, including content and sign-sheets must be available at any time for review by the Agency upon request.

6. Facility administration will assess the facility policy and practice of periotic checks of residents, with special emphasis on all new admissions, residents with significant changes, and residents with behavioral patterns of exit seeking. This will be completed by the Assisted Living Facility Administrator no later than , 2016.

7. The facility will develop and implement system(s) to ensure exit doors are monitored in order to minimize the risk of resident elopement. The Assisted Living Facility Administrator will continually evaluate the effectiveness of the system(s) utilized to monitor the facility exit doors and make changes when necessary to ensure that the system(s) are meeting the needs of the residents. There will be an effective system(s) in place to monitor all exit doors by no later than , 2016. Monitoring the effectiveness of the system(s) will be ongoing. Documentation of the monitoring must be available at any time for review by the Agency upon request.

Sandhill Gardens Retirement Center
, 2016

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 or Jon Seehawer, R.N., Field Office Manager, at (239) 335-1315.

Sincerely,

Jon Seehawer, RN
Field Office Manager

Accepted by: _____

Printed Name: _____

Title: _____

Date: _____

sh

D7JR

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

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2295 Victoria Avenue,
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