STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964056	07/26/2016
NAME OF PROVIDER OR SUPPLIER **BELVEDERE COMMONS OF TAMPA**	STREET ADDRESS, CITY, STATE, ZIP CODE **1513 WEST FLETCHER AVENUE TAMPA, FL 33612**	

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

0000 Initial Comments

Assisted Living Facility

A complaint survey, (CCR# 2016008153), was conducted from - at Belvedere Commons of Tampa, (License # 8803), located at 1513 West Fletcher Ave, Tampa, FL. Deficiencies were identified during the survey.

0025 Resident Care - Supervision

Based on interview, observation, and record review, the facility failed to protect the safety of 22 out of 22 residents by failing to lock and reset the alarm doors in the secured memory care facility, and failing to follow their own internal policy for maintaining the security of an alarmed exit designed to provide security for a resident with exit seeing behavior. The facility also failed to implement additional measures for 1 out of 22 sampled residents (Resident #1) with a previous elopement and known exit-seeking behaviors. This led to Resident #1 leaving the facility and directly contributed to his .

Findings included:

On a record review was conducted of the internal incident report, no date listed, completed by Staff A. The date of the incident was identified as and the time was 7:00 PM. The description of the incident as written by Staff A read " Resident eloped around 7pm through the fire doors on C hall. R.A. brought one resident back from the door looked for the other resident (Resident #1) out of the internal fire door, not out of the external fire door. Realizing one resident was missing a search of the building was done and also the perimeter of the building outside around the . After 40 min of searching protocol was followed management was called family was called then police were called. "
On at 2:30 PM an observation was made of the emergency exit doors. The inner and outer emergency exit doors are connected to the alarm panel. The alarm panel shows a red light when either the inner door or outer door is closed, and a green light when either door is open. The outer door can be pulled shut, with the door unlocked and the alarm off. The control panel at the end of the hallway can be reset to show a red light, indicating it is closed, even though it may be unlocked and the alarm off. The panel does not show if the door is locked and the alarm is set.
The Executive Director demonstrated how the outer door works. The door was alarmed and locked. The bar on the door had to be pressed and then 40 seconds later the door would open. An alarm would sound. A key was required to turn off the alarm on the bar. It was turned in one direction until the alarm went off, and then turned in another direction to reset it. When the inner alarm was turned off, the outer door alarm could be heard from the opposite end of the hallway, through the closed inner door.

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On at 9:15 AM a record review was conducted of the chart for Resident #1. Resident #1 was admitted to the facility on . AHCA Health Assessment Form 1823 (1823) dated / showed a diagnosis of ' s/ , identified Resident #1 as an elopement risk, and stated he required supervision for ambulation. Resident #1 returned from the hospital with a new 1823 dated / and did not identify Resident #1 as an elopement risk, and stated he needed assistance with ambulation. The newest 1823 in the file was dated . Resident #1 was not identified as an elopement risk. Special precautions were identified as and safety. Resident #1 was listed as requiring total care for ambulation. Under the category " observe wellbeing " a comment indicated " sitter. "

On at 9:25 AM an interview was conducted with the Executive Director. She stated the two 1823 ' s obtained after Resident #1 was admitted came back with him from the hospital. She stated the doctors in the hospital probably did not know him very well. She stated each time he returned from the hospital he was having difficulty ambulating. The Executive Director said Resident #1 was able to ambulate independently again after receiving physical , and they should have obtained a new 1823. She further stated the resident had a sitter when he returned from the hospital, but was discontinued after he was steadier on his feet. They did not receive an order to stop the sitter, and she stated they should have obtained a new 1823 for that reason as well.

On a record review was conducted of the written statement dated written by Staff A. Staff A wrote in her statement that the " incident happened around 7pm when the emergency alarm went off on C Hall. "

On a record review was conducted of the written statement dated written by Staff B. Staff B wrote that the alarm went off " around 6:30 " PM in Hallway C. She saw Resident #2 in the exit area between the inner and outer emergency exit doors. She wrote " I didn ' t check the other exit door, until I was told it was unlocked. So I went back and checked outside and Resident #1 was not there. "

On a record review was conducted of the written statement dated written by Staff C. Staff C wrote that the alarm went off " around 6:45 PM " . Staff C was assisting a resident in her , and when Staff C came out a few minutes later he was told Resident #1 was missing.

On a record review was conducted of the facility ' s elopement policy and procedures. The policy stated " all new employees will be trained on preventing elopement and their role and responsibilities if an elopement occurs. " It also read " an Elopement Risk Assessment and Intervention form will be completed upon move-in, annually and whenever a residents risk for elopement increases such as with an increase in exit-seeking behavior or after a post-elopement episode. " The policy further read " a daily check of all alarmed doors is the responsibility of the Wellness Department. This check is to confirm that all doors are activated and working correctly. This daily check is documented on the Alarm Door/Gate Check (healthcare) form. Any door not working properly will be reported to the Maintenance Director immediately. " Phase One of the elopement procedure stated that when a resident is discovered missing, the supervisor will be notified immediately, and then a search will be

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conducted of the residence and grounds. " This phase should take no more than 15 minutes. " Phase Two of the procedure states the supervisor will immediately notify the Executive Director. At this time an employee will be assigned to search the area on foot and an employee will be designated to search the area by car. " This phase should last no more than 15 minutes. " Phase Three stated " the ranking management person in the facility will notify the Regional Director of Operations and the responsible partv. The local police will be notified " .

On at 1:05 PM an interview was conducted with Staff A. Staff A stated she began working at the facility on . In regards to elopement policy and procedure training she stated " They told me the process for the alarms. Said when you have people trying to escape, how to turn off the alarm with the key . " She said her training was just alarm and keypads. She stated she didn ' t know what the policy was for the facility, but knew they had to find the missing person. " We have people ' missing ' all the time. They are usually in someone else ' s a the laundry. "

On a continued interview was conducted with Staff A. She stated she was at her medication cart when the emergency exit door alarm went off. She stated she went to the key at by the front of the building. Staff B went to the door in hallway C where the alarm had sounded and redirected Resident #2. Staff A reset the alarm panel and noticed the exterior door was still green, indicating it was still open. Staff A asked Staff B who had opened the second door. Staff B told her no one had, that she had located Resident #2 in between the inner emergency exit door and the outer emergency exit door. Staff B told Staff A she had last seen Resident #1 with Resident #2 and she was looking for him. Staff A told Staff B to go look out the outer door for Resident #1. Staff B went to look out the door, came back, and said she had not seen Resident #1. Staff A stated they searched the building for approximately 10 minutes. They did not locate Resident #1 in the building. Staff B said she would go check the gas station, which was close to the exit door Resident #1 used. Staff A told her to go and told Staff C to go in his car and search the area. She stated while the other two employees were gone, she searched the two hallways they had searched again. " We searched the building first. From the moment we realized he was missing until I decided he was missing and needed to call the Executive Director, about 40 minutes . " Staff A stated she went into the office to call the Executive Director (Director) and as soon as it started to ring the Caller ID displayed an incoming call from Resident #1 ' s daughter. She answered the phone and told the daughter they had " lost her father. " The daughter asked if she had called 911, and she said she had not. She told the daughter she would as soon as she got off the phone. The family member ended the call to come help search for Resident #1. Staff A called and informed the Executive Director of the elopement and asked what to do. The Executive Director told her to call the police. Staff A stated she then called the police.

On at 12:11 PM an interview was conducted with Staff B. Staff B stated she heard the alarm go off and she ran to the emergency exit in C hall. She stated she saw Resident #2 " in between the first and second door. I went and pulled him back and turned off the alarm. Didn ' t check the other door(outer door). I didn ' t know we were supposed to. " She stated she had only been working at the facility for 3 weeks. Staff B stated when she turned off the alarm on the inner door, no alarm was

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sounding from the outer door. She took Resident #2 ' s hand and walked up front with him to the medication cart. Staff A asked if anyone had breached the outer door because the outer door was still open. Staff B stated she thought Resident #1 had just wandered off to someplace else in the facility. She went back to check the outer door and it was cracked just a little. No alarm went off when she pushed the door open. She didn ' t have to wait for 40 seconds. She checked outside, pulled the door shut, turned the key and then it made a noise, she took it out and redid it and the noise stopped. Staff B stated they searched the building for about 15 minutes. " We searched it over and over. Searched for 30 minutes to an hour, all three of us. We were thinking he had to be in there. " She said after that, she went outside to search on foot. After they searched and he was not located, Staff A went to phone the Director. As she was calling, Resident #1 ' s daughter called, and Staff A told her he was missing.

On at 1:20 PM an interview was conducted with the Executive Director in regards to how long she estimated it would take Staff B to walk from the back up front, and then return to the door to check for Resident #1. The Executive Director stated Resident #2 walks very slow. She stated it would take several minutes to walk with him from the exit door in Hallway C to the front where Staff A had been located with the medication cart.

On at 1:49 PM an observation was made of Resident #2 as he walked with an employee. Resident #2 walked 25 feet in 35 seconds. The distance from the emergency exit in Hallway C to the location where Staff B walked with Resident #2 to Staff A at the medication cart was approximately 140 feet.

On at 2:47 PM an interview was conducted with Staff C. He began working at the facility on . Staff C stated he was working with a resident and heard the alarm sound, but he did not respond to it, as he was busy. He stated he heard it go off a minute later, which meant someone else had responded. He said he finished assisting the resident, and left the few minutes later. By then Staff A and Staff B had determined Resident #1 was missing. He stated Staff B must have been , because she said she did not check the outer door, and it is their procedure to check the outer door, even if it does not appear the door has been breached. Staff C stated they searched the building for 10 minutes. He said he then searched by car for 30-40 minutes. When he returned to the facility Staff A had already informed the Director, the family, and the police. Staff C stated he only works weekends and he has not participated in an elopement drill. Staff C stated the inner door has numbers on a panel at the door to reset the alarm. He stated for the outer door " turn it clockwise once and it locks and resets the alarm. That ' s supposed to be it. Then go to panel in hallway and reset. "

On at 4:07 PM an observation was conducted of the Executive Director as she turned off the alarm and reset it at the outer emergency exit where Resident #1 exited. She inserted the key into the bar and stated " turn it up to silence it, and then turn it back 180 degrees to lock it. " It appears Staff C was not aware of the correct procedure to lock and secure the emergency exit, as he stated he turned the key clockwise once to lock and reset the alarm.

On at an interview was conducted with the Executive Director (Director). She indicated she received a missed call from the facility at approximately 7:45 PM. She called back and Staff B told her

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Staff A was on the phone with the family and she would call the Executive Director back. She stated at 7:48 PM Staff A called her and informed her that Resident #1 was missing, they had performed a search inside the building, outside of the building, and Staff C had performed a search in his vehicle. Staff A told her she then called the family and the Executive Director. The Director told Staff A to call the police 911 and report an elopement. The Director contacted her Wellness Director and Marketing Director to meet her at the building to assist with the search. She got to the building and the police were on site.

On at 9:48 AM in a continued interview with the Director, she stated she did not know what the Alarm Door/Gate Check (healthcare) form was. The Director said the employees are supposed to check the doors daily to verify they are locked, but they do not document it anywhere.

On at 9:49 AM an interview was conducted with the Regional Manager. The Regional Manager stated she was not familiar with the Alarm Door/Gate Check (healthcare) form. She stated the alarms go off daily by the residents pushing them, so they know they are working. She later said the Alarm Door/Gate Check form on the elopement policy is not in use.

In a continued interview with the Regional Manager on at 5:15 PM, she stated the first phase of the elopement procedure is 15 minutes, and the second phase is 15 minutes. The Regional Manager stated the Executive Director should have been notified after 15 minutes but she was not informed until 7:48 PM. She stated the police should be notified after 30 minutes, but they were not notified until 7:59 PM. The family should have been called by the facility and notified at 30 minutes, but they were not notified until they called the facility at 7:47 PM, an hour and 5 minutes after the resident eloped.

On at 3:49 PM a review was conducted of the alarm code history. The alarm was set off at 6:42 PM and 6:45 PM on , the night of the elopement.

On / at 4:35 PM a record review was conducted of the police report for the elopement. The call was placed to the police at 7:59 PM on .

On / at 2:47 PM an interview was conducted with Staff D. Staff D stated Resident #1 previously eloped from the facility on / . She stated he displayed exit-seeking behaviors and she would label him high risk for elopement. Staff D stated Resident #1 was most active at night, and he was able to ambulate very well on his own. Staff D further stated the outer exit door has been found to be unlocked on a few occasions.

On at 2:00 PM a record review was conducted of the chart for Resident #1. A note in the Resident Log dated / 7:30 read " Resident outside on property. Exited through emergency exit turned right on the sidewalk about 75 ft. Response time 15 seconds lead resident back in building. Called Wellness Director & daughter. " Signed by Staff D.

An interview was conducted with the Executive Director at 2:05 PM. She stated she was not aware of a previous elopement of Resident #1. She stated there is no incident report documenting the details of the elopement. and no adverse incident report was filed with the Agency.

On at 2:12 PM an interview was conducted with Staff D. Staff D stated on / at approximately 7:30 PM she was outside of the break I heard the alarm go off. She stated " he moves fast " so she had to run. She said it took her about 5 seconds to get to the exit, and he had

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already breached both the inner and the outer emergency exit doors. The outer door he went through has a 30 second delay when the door is locked and the alarm is set. Staff D stated when she went out the outer door he had already made it 75 feet down the sidewalk and turned to the right. Staff D stated she caught up with Resident #1 and led him back inside. She stated she wrote a note in the Resident Log, filled out an incident report, and called the Wellness Director. She stated she told Resident #1 ' s daughter in person when she arrived at the facility a little while later. She stated she took the incident report and placed it " under the plastic " on the desk in the office of the Wellness Director, which she stated was the location she was told to place any incident report.

On at 4:33 PM an interview was conducted with Staff F. Staff F stated she was aware that Resident #1 was previously about to get out of the building past the second door. She stated when the alarm sounds and she is on her way to the door she looks at the panel to see if both the inner and outer door are green or red. If she sees two doors are open she tells the nurse and goes out and brings them back. Staff F stated they have to " do it all the time. " When further questioned she said only Resident #1 has made it past the outer door.

On at 1:57 PM an interview was conducted with the Wellness Director. She stated she did not recall having a conversation with Staff D regarding Resident #1 eloping from the facility. She stated she did not remember seeing an incident report regarding the elopement either. The Wellness Director stated she does not review the notes written in the Resident Log. She stated she will review the 24-hour report sheet. She stated no additional precautions were put into place for Resident #1 because she was unaware that he had previously been able to get out of the building. She stated he should have had a Safetv Net GPS wrist guard obtained for him after his first elopement.

On at 3:30 PM a record review was attempted of the 24-hour report sheet from // . The Executive Director stated she was unable to locate them, and was told the Wellness Director throws them out. They are not kept in the building.

On at 11:17 AM an interview was conducted with the family of Resident #1. Family member #1 stated she called the facility to say she was coming to visit her father, and was told Resident #1 was missing. The facility did not call her. She stated she was concerned that Resident #1 eloped earlier, and they didn ' t inform the family or police in a timely manner. The family member stated she was not approached about any additional interventions for her father, who was displaying exit seeking behavior. The family member stated even though Resident #1 ' s 1823 stated he was unable to ambulate by himself and required total care with ambulation, he was " very mobile, very quick. " She stated that 1823 was filled out when he was in the hospital and he had just had surgery in the area. She stated he recovered from the surgery.

On at a record review was conducted of the Elopement Risk Evaluation and Interventions form dated . The form ranked the resident on a scale between 1 (low risk) and 15 (high risk) of their risk of elopement. Resident #1 was rated as a 5. For the score of 4-8 the form stated " Implement Elopement Program Interventions. " A reassessment dated also had Resident #1 listed as a 5. Question #10 on the form read " Resident has eloped from facility*. An (*) indicates

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resident requires an immediate secure environment and/or direct supervision. " The form had " No " filled in for question #10, although he had eloped from the facility on / .
On an interview was conducted with the Wellness Director. The Wellness Director stated she was not aware that Resident #1 eloped from the facility. She stated she performed an Elopement Risk Evaluation when Resident #1 was admitted to the facility and when he returned from the hospital. She stated to perform these evaluations, she did not interview direct care staff, the nurse who works with the resident, or read the notes in the resident ' s chart. She stated she reads the notes from the hospital and observes the resident for about 24 hours after he returns from the hospital. The Wellness Director did not know what the Elopement Program Interventions were. She then stated they were to check on the residents. " Keep an eye on where they are at. Make sure they are not left alone. "
A record review was conducted on of the 1823 and the Elopement Risk Evaluation and Intervention form for each resident in the facility. Four residents were identified as an elopement risk on the 1823. One resident was identified as a moderate elopement risk using the Elopement Risk Evaluation and Intervention form. A review of both forms for Resident #2 showed he was not an elopement risk on the 1823 dated , and he was listed as low risk (2) on the Elopement Risk Evaluation and Interventions form dated / , as well as low risk (3) on the form dated . " Resident follows or attempts to follow others leaving building " was marked as " No " , when Resident #2 attempted to follow Resident #1 out of the building, and was located in between the two emergency exit doors. Resident #2 was also identified as an elopement risk by Staff D during an interview on at 11:06 AM.
On at 2:54 PM an interview was conducted with a police detective who had been assigned to the investigation. He stated Resident #1 was observed knocking on doors in the area on Sunday morning, and it is believed he went into a local lake on Sunday afternoon. Detective stated the body located in the local lake had been positively identified as Resident #1. He stated an autopsy has been performed for exact cause of . The Detective further stated that based on the history of Resident #1 he would have recommended the Safety Net GPS. He stated if Resident #1 had been wearing the Safety Net the police could have located him before he went into the lake.

Class I

0032 Resident Care - Elopement Standards

Based on interview and record review, the facility failed to ensure the safety of 22 out of 22 residents in the facility. Specifically, the facility failed to follow its own elopement policy and procedure, including maintenance of exits and alarms, and notification of staff, family, and law enforcement, leading to the elopement of 1 out of 22 sampled residents (Resident #1).

Findings included:

AGENCY FOR HEALTH CARE ADMINISTRATION

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On a record review was conducted of the facility's elopement policy and procedures. The policy stated " all new employees will be trained on preventing elopement and their role and responsibilities if an elopement occurs. " It also read " an Elopement Risk Assessment and Intervention form will be completed upon move-in, annually and whenever a residents risk for elopement increases such as with an increase in exit-seeking behavior or after a post-elopement episode. " The policy further read " a daily check of all alarmed doors is the responsibility of the Wellness Department. This check is to confirm that all doors are activated and working correctly. This daily check is documented on the Alarm Door/Gate Check (healthcare) form. Any door not working properly will be reported to the Maintenance Director immediately. " Phase One of the elopement procedure stated that when a resident is discovered missing, the supervisor will be notified immediately, and then a search will be conducted of the residence and grounds. " This phase should take no more than 15 minutes. " Phase Two of the procedure states the supervisor will immediately notify the Executive Director. At this time an employee will be assigned to search the area on foot and an employee will be designated to search the area by car. " This phase should last no more than 15 minutes. " Phase Three stated " the ranking management person in the facility will notify the Regional Director of Operations and the responsible party. The local police will be notified " .
On at 3:49 PM a review was conducted of the alarm code history. The alarm was set off at 6:42 PM and 6:45 PM on , the night of the elopement of Resident #1.
On / at 4:35 PM a record review was conducted of the police report for the elopement. The call was placed to the police at 7:59 PM on .
On a record review was conducted of the written statement dated written by Staff A. Staff A wrote in her statement referring to Resident #1 leaving the facility that the " incident happened around 7pm when the emergency alarm went off on C Hall. "
On a record review was conducted of the written statement dated written by Staff B. Staff B wrote that the alarm went off " around 6:30 " PM in Hallway C. She saw Resident #2 in the exit area between the inner and outer emergency exit doors.
On at a record review was conducted of the written statement dated written by Staff C. Staff C wrote that the alarm went off " around 6:45 PM " . Staff C was assisting a resident in her and when he came out a few minutes later he was told Resident #1 was missing.
On at 1:05 PM an interview was conducted with Staff A. Staff A stated she began working at the facility on / . In regards to elopement policy and procedure training she stated " They told me the process for the alarms. Said when you have people trying to escape, how to turn off the alarm with the key ' . " She said her training was just alarm and keypads. She stated she didn ' t know what the policy was for the facility. Staff A stated she has not participated in an elopement drill since she was hired. Staff A stated in regards to the other two employees working with her the night of the incident " I wouldn ' t say they were trained on what to do, no. "
On a continued interview was conducted with Staff A, the supervisor on shift on .

AGENCY FOR HEALTH CARE ADMINISTRATION

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Staff A stated she was at the front of the building when the emergency exit door alarm went off (6:42 PM). She stated she went to the key at by the front of the building. Staff B went to the door in hallway C where the alarm had sounded and redirected Resident #2 away from the exit. Staff A reset the alarm panel and noticed the exterior door was still green, indicating it was still open. Staff A determined Resident #1 was missing and coordinated a search of the building. She stated after they searched the building, she sent Staff B to search the grounds and Staff C to search the area by car. " We searched the building first. From the moment we realized he was missing until I decided he was missing and needed to call the Executive Director, about 40 minutes. " Staff A stated she went into the office to call the Executive Director (Director) and as soon as it started to ring the Caller ID displayed an incoming call from Resident #1 ' s daughter (7:47 PM). She answered the phone and told the daughter they had " lost her father. " The daughter asked if she had called 911, and she said she had not. She told the daughter she would as soon as she got off the phone. Staff A called and informed the Executive Director of the elopement and asked what to do(7:48 PM). The Executive Director told her to call the police. Staff A stated she then called the police (7:59 PM). Staff A failed to notify the Executive Director when Resident #1 was not located inside the building after searching for no more than 15 minutes, which would have been 6:57 PM. Staff A also failed to notify police and the family when Resident #1 was not located on the grounds or in the area after 30 minutes, which would have been 7:12 PM.

On at 12:11 PM an interview was conducted with Staff B. Staff B stated around 6:30 PM (6:42 PM)she heard the alarm go off and she ran to the emergency exit in C hall. She stated she saw Resident #2 " in between the first and second door. I went and pulled him back and turned off the alarm. Didn ' t check the other door(outer door). " She stated she had only been working at the facility for 3 weeks. Staff B stated when she turned off the alarm on the inner door, no alarm was sounding from the outer door. She took Resident #2 ' s hand and walked up front with him to the medication cart. Staff A asked if anyone had breached the outer door because the outer door was still open. She went back to check the outer door and it was cracked just a little. No alarm went off when she pushed the door open. She didn ' t have to wait for 40 seconds. She checked outside, pulled the door shut, turned the key and then it made a noise, she took it out and redid it and the noise stopped. Staff B stated they searched the building " for about 15 minutes. " Staff B further stated " We searched it over and over. Searched for 30 minutes to an hour, all three of us. We were thinking he had to be in there. " She said after that, she went outside to search on foot. After they searched and he was not located, Staff A went to phone the Director. As she was calling, Resident #1 ' s daughter called, and Staff A told her he was missing.

On at 2:47 PM an interview was conducted with Staff C. He began working at the facility on . Staff C stated he was working with a resident and around 6:45 PM he heard the alarm sound, but he did not respond to it, as he was busy. He stated he heard it was turned off a minute later, which meant someone else had responded. He said he finished assisting the resident, and left the few minutes later. By then Staff A and Staff B had determined Resident #1 was missing. Staff C stated they searched the building for 10 minutes. He said he then searched by car for 30-40 minutes. When he returned to the facility Staff A had already informed the Director, the family, and the police. Staff C stated

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	AL11964056	07/26/2016
NAME OF PROVIDER OR SUPPLIER **BELVEDERE COMMONS OF TAMPA**	STREET ADDRESS, CITY, STATE, ZIP CODE **1513 WEST FLETCHER AVENUE TAMPA, FL 33612**	

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(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

he only works weekends and he has not participated in an elopement drill. Staff C stated the inner door has numbers on a panel at the door to reset the alarm. He stated for the outer door " turn it clockwise once and it locks and resets the alarm. That ' s supposed to be it. Then go to panel in hallway and reset. "

On [redacted] at 8:57 AM an interview was conducted with the Executive Director (Director). She indicated she received a missed call from the facility at approximately 7:45 PM. She called back and Staff B told her Staff A was on the phone with the family and she would call the Executive Director back. She stated at 7:48 PM Staff A called her and informed her that Resident #1 was missing, they had performed a search inside the building, outside of the building, and Staff C had performed a search in his vehicle. Staff A told her she then called the family and the Executive Director. The Director told Staff A to call the police 911 and report an elopement. The Director contacted her Wellness Director and Marketing Director to meet her at the building to assist with the search. She got to the building and the police were on site.

On [redacted] at 9:48 AM in a continued interview with the Director, she stated she did not know what the Alarm Door/Gate Check (healthcare) form was that was listed in the Elopement policy and procedure. The Director said the employees check the doors daily to verify they are locked, but they do not document it anywhere.

On [redacted] at 9:49 AM an interview was conducted with the Regional Manager. The Regional Manager stated she was not familiar with the Alarm Door/Gate Check (healthcare) form that was identified in the Elopement policy and procedure. She stated the alarms go off daily by the residents pushing them, so they know they are working. She later said the Alarm Door/Gate Check (healthcare) form on the elopement policy is not in use.

In a continued interview with the Regional Manager on [redacted] at 5:15 PM, she stated the first phase of the elopement procedure is 15 minutes, and the second phase is 15 minutes. The Regional Manager stated the Executive Director should have been notified after 15 minutes but she was not informed until 7:48 PM. The Regional Manager stated the police should be notified after 30 minutes, which would have been 7:12 PM. Family should have been contacted by the facility at that time as well.

On [redacted] at 2:47 PM an interview was conducted with Staff D. Staff D stated Resident #1 previously eloped from the facility on [redacted]. She stated he displayed exit-seeking behaviors and she would label him high risk for elopement. Staff D stated Resident #1 was most active at night. Staff D stated the outer exit door has been found to be unlocked on a few occasions. Staff D stated she did not know what " Elopement Program Interventions " were. She stated she would have to " guess " at what they were. She stated the Wellness Director " handles all of that. " She stated she did not understand how Resident #1 was not identified as an elopement risk.

On [redacted] at 11:17 AM an interview was conducted with the family of Resident #1. Family member #1 stated she called the facility at 7:47 PM to say she was coming to visit her father, and was told Resident #1 was missing. The facility did not call her. Staff A told her Resident #1 received his medications at 6:30 PM and he left at some time after that. She stated she was concerned that Resident

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#1 eloped earlier, and they didn ' t inform the family or police in a timely manner. The family member stated she was not approached about any additional interventions for her father, who was displaying exit seeking behavior

On a record review was conducted of the Elopement Risk Evaluation and Interventions form dated . The form ranked the resident on a scale between 1 (low risk) and 15 (high risk) of their risk of elopement. Resident #1 was rated as a 5. For the score of 4-8 the form stated " Implement Elopement Program Interventions. " A reassessment dated also had Resident #1 listed as a 5. Question #10 on the form read " Resident has eloped from facility*. An (*) indicates resident requires an immediate secure environment and/or direct supervision. " The form had " No " filled in for question #10 although he had eloped from the facility on .

On at 1:57 PM an interview was conducted with the Wellness Director. The Wellness Director stated she was not aware that Resident #1 previously eloped from the facility.

On at 5:12 PM an interview was conducted with the Executive Director. She stated she was not aware that Resident #1 had a prior elopement from the facility. She stated he should have been reassessed at that time for elopement risk, and per their elopement policy, an individual service plan should have been developed, which would have included a Safety Net GPS device.

On at 2:54 PM an interview was conducted with a police detective who had been assigned to the investigation. He stated Resident #1 was observed knocking on doors in the area on Sunday morning, and it is believed he went into a local lake on Sunday afternoon. Detective stated the body located lake had been positively identified as Resident #1. He stated an autopsy has been performed for exact cause of . The Detective further stated that based on the history of Resident #1 he would have recommended the Safety Net GPS. He stated if Resident #1 had been wearing the Safety Net the police could have located him before he went into the lake.

Class II

0054 Medication - Records

Based on record review and interview, Staff failed to immediately update the medication observation record (MOR) for 1 out of 1 (Residents #1) sampled resident each time the medication is offered or administered.

Findings included:

On at 1:05 PM an interview was conducted with Staff A. Staff A stated she provided the medications to Resident #1 during dinner, which was served between 5:00-5:10 PM. She stated she crushed the medication and put the medications in his juice, and then watched him drink the juice to make sure he received his medications. Staff A stated she signed the MOR around 6:20 PM, but she

AGENCY FOR HEALTH CARE ADMINISTRATION

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provided the medications earlier, around 5:45 PM.
On a record review was conducted of the electronic MOR system. Two medications were signed for on the electronic MOR at 5:45 PM. Five medications were signed for at 6:20 PM.
On at 1:50 PM an interview was conducted with the Regional Manager. She stated Staff A told her she gave Resident #1 his medications at 5:45 PM and " pushed the button " on the electronic MOR at 6:20 PM. The Regional Manager stated she told Staff A the MOR needs to be signed immediately, not later.

Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and interviews, the facility failed to file the required adverse incident report to the agency for an adverse incident for an elopement for 1 out of 5 (Residents #1) sampled residents, within one business day.

Findings included:

On at 2:00 PM a record review was conducted of the chart for Resident #1. A note in the Resident Log dated / / 7:30 read " Resident outside on property. Exited through emergency exit turned right on the sidewalk about 75 ft. Response time 15 seconds lead resident back in building. Called Wellness Director & daughter. " Signed by Staff D.
An interview was conducted with the Executive Director at 2:05 PM. She stated she was not aware of a previous elopement of Resident #1. She stated there is no internal incident report documenting the details of the elopement, and no adverse incident report was filed with the Agency.
On at 2:12 PM an interview was conducted with Staff D. Staff D stated on / at approximately 7:30 PM she was outside of the break ! heard the alarm go off. She stated " he moves fast " so she had to run. She said it took her about 5 seconds to get to the exit, and Resident #1 had already breached both the inner and the outer emergency exit doors. The outer door he went through has a 30 second delay when the door is locked and the alarm is set. Staff D stated when she went out the outer door he had already made it 75 feet down the sidewalk and turned to the right. Staff D stated she caught up with Resident #1 and led him back inside. She stated she wrote a note in the Resident Log, filled out an internal incident report, and called the Wellness Director. She stated she told Resident #1 ' s daughter in person when she arrived at the facility a little while later. She stated she took the internal incident report and placed it " under the plastic " on the desk in the office of the Wellness Director, which she stated was the location she was told to place any incident report.
On at 1:57 PM an interview was conducted with the Wellness Director. She stated she did not recall having a conversation with Staff D regarding Resident #1 eloping from the facility. She stated

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she did not remember seeing an internal incident report regarding the elopement either.
On a review was conducted of the Agency ' s system. No adverse incident report was located for Resident for I/ .

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Attn: Tracey Earle-Crowell, Administrator
FKP Tampa Senior Living LLC dba Belvedere Commons of Tampa
1513 W Fletcher Avenue
Tampa, FL 33612-3315

Dear . Earle-Crowell:

This letter reports the findings of a complaint inspection survey conducted on
20- , 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) for each area as stated below.

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 - 0032 - 58a-5.0182(8) Fac- Resident Care - Elopement Standards Class II

Your facility must comply with the following:

1. The Assisted Living Facility shall update their existing policy and procedure related to elopement to ensure the policy contains, 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.
   The policy must also contain requirements for updating the elopement assessments on each resident. The updated assessment process must include consultation with direct care staff familiar with the resident, interview with family/responsible party, interview with the resident's health care provider and a review of the resident record.
   The elopement policy must also contain information on maintaining and monitoring the facility's exit doors and alarm systems and monitoring of the alarm panel indicating a breach of the secure exits. The policy also indicate specifics on training staff on maintaining the secure exits, monitoring and setting the alarms and notifying maintenance of the status of the exits and alarms. In addition, all residents of the facility must have a new elopement assessment in accordance with the new assessment policy and process. As part of the ongoing assessment, the resident must be reassessed if the resident undergoes a significant change or displays increased exit-seeking behaviors.

This must be completed by , 2016.

2. All facility staff must be trained on the policy in item #1. Documentation of the training, including content and sign-in sheets, must be maintained in the facility and available for review by the Agency upon request. **This must be completed by , 2016.**

3. In addition to training on the facility policy, all staff of the facility will participate in elopement drills. These drills will be conducted on ALL shifts. The next elopement drill will be completed by no later than 3 days of receiving this letter. Documentation of the elopement drills, including content and sign-sheets must be available at any time for review by the Agency upon request. **This must be completed by , 2016.**

4. Facility administration will create and implement a facility policy and practice of periodic checks of residents, with special emphasis on all new admissions, residents with significant changes, and residents with behavioral patterns of exit seeking. The completion of these periodic checks must be documented. This will be completed by the Administrator no later than , **2016.**

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

Should you have any questions, please contact **Laura Manville**, Assisted Living Facility Enforcement Team Manager at 727-552-1955 or **Paul Brown**, Health Facilities Evaluator Supervisor, at 727-552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

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