STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967417	**03/07/2018**
NAME OF PROVIDER OR SUPPLIER **BEACON AT GULF BREEZE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **4410 GULF BREEZE PARKWAY** **GULF BREEZE, FL 32563**	

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

0000 - Initial Comments

An unannounced complaint survey for allegations contained within CCR# 2018000268 was conducted at The Beacon at Gulf Breeze, an assisted living facility, from - . The license number is #11456. Deficient practice was found at the time of the survey.

0028 - Resident Care - Activities of Daily Living - 58A-5.0182(4) FAC

Based on observation of lunch and dinner in memory care, staff interview and record review, the facility failed provide timely assistance with meals for 3 of 5 residents observed (#1, #4, and #5) for lunch and 3 of 4 residents for dinner (#1, #4 and #5).

The findings were:

The memory care unit was staffed with 4 resident assistants ( ), which included 1 agency staff,and there was 1 licensed practical nurse . During meals there was one additional dining person who helped serve plates. There were total 38 residents in the memory care unit.

On at 11:00 am, the lunch meal was observed to be starting in the memory care dining . 5 residents were observed to be sitting at a long table in the back of the dining . A plate of food was placed on the table out of the residents reach for each. At 11:10 am, 2 staff members started to assist resident #2 and #3 with their meals while residents #1, #4, and #5 sat at the table waiting to be served. The 3 residents plates remained in the center of the table (#1, #4, #5). During the meal both RAs were observed to stop assisting resident #2 and #3 twice to pull residents #2 and #4 back up in their wheelchairs. At 11:25am, a began to assist resident #1. At 11:30am, a began to assist resident #4. While waiting for assistance with her meal, resident #5 was observed to be sleeping at the table in her wheelchair. At approximately 11:40am, a 3rd reheated resident #5's food which had sat on the table for at least 30 minutes and began to assist her with her meal. Resident #5 appeared to still be sleepy and ate very little of the meal that the was attempting to assist the resident with .

On at 12:16pm, Staff H ( ) was interviewed. She stated that staff started bringing residents into the dining 10:30am to 10:45am for lunch. Staff H stated that the 5 residents requiring assistance with meals were all sat at the same table and that there were two RAs to assist 5 residents. She stated, "we assist them as soon as we can". When asked about resident #5 having to wait a long time for assistance with meals, Staff H replied, "No I do not think you should have to wait that long to eat."

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967417	03/07/2018
NAME OF PROVIDER OR SUPPLIER **BEACON AT GULF BREEZE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **4410 GULF BREEZE PARKWAY GULF BREEZE, FL 32563**	

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

A record review conducted for resident #1 revealed the resident to be under the care of hospice. A review of the resident's most recent Resident Health Assessment for Assisted Living Facilities Form (1823) indicated the resident required assistance with all her activities of daily living (ADL) to include eating.

A record review conducted for resident #2 revealed the resident to be under the care of hospice. A review of the resident's most recent 1823 revealed the resident needed assistance with all her ADLs to include assistance with eating.

A record review conducted for resident #3 revealed the resident to be under the care of hospice. A review of the resident's most recent 1823 revealed the resident to also require assistance with all ADLs to include assistance with eating.

A record review conducted for resident #4 revealed the resident to be under the care of hospice. A review of the resident's most recent 1823 revealed the resident to also require assistance with all ADLs to include assistance with eating.

A record review conducted for resident #5 revealed the resident to be under the care of hospice. A review of the resident's most recent 1823 revealed the resident to also require assistance with all ADLs to include assistance with eating.

On at 3:35 pm, residents were observed being placed in the dining dinner by staff. The dinner meal was scheduled to start at 4:00pm. During this meal observation, residents #1, #2, #4, and #5 were observed again to be sitting at a back table in the dining . The Director of Nursing (DON) and Executive Director (ED) were in the dining , this surveyor's observation. Both the DON and ED assisted with serving residents their plates. Resident #2 was a immediately assisted with her meal at 4:00pm by a family member at another table. Residents #1, #4, and #5 continued to sit at the table waiting for staff to assist them. At 4:31pm, resident #5 was observed to be leaning over to the right side in her wheelchair sleeping. Following resident #5's observation, staff K was interviewed and she revealed the resident's and , medications were being held due the resident sleeping a lot. Staff K indicated this was the 2nd night resident #5's medication had been held. Resident #5 was taking to her put to bed without eating during the meal time. The DON assisted resident #4 at 4:38 with eating her meal; resident #1 still sat at the table waiting to be assisted. At 4:47pm, a assisted resident #1 with her meals.

An interview was conducted with the ED and the DON on at 5:33 pm. The DON stated, "We are trying to find a solution for dining in the memory care. We want to put one or 2 feeders with

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967417	03/07/2018
NAME OF PROVIDER OR SUPPLIER **BEACON AT GULF BREEZE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **4410 GULF BREEZE PARKWAY GULF BREEZE, FL 32563**	

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

prompters at different tables". The ED changed the [illegible] to "people who need assistance." The ED and DON were asked, "Should any resident be required to sit at a table while others are being assisted with eating and wait for 40 minutes to get assistance? The ED stated, "No, we have a higher acuity level back there maybe we need more staff? We have lot of people who need assistance with dining." She was then asked "Were there enough staff to assist with dining and eating today for the residents in memory care. She stated, "No".

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on staff interview, resident record review and policy review, the facility failed to ensure policy and procedures addressed the minimum requirements for elopement risk residents and failed to ensure 1 of 1 (#8) resident had required identification in place.

The findings were:

On at 2:07 pm, an interview was conducted with the Executive Director (ED). She was asked if the facility had any elopements in the past six months. She stated, "No, we have not had any elopements off the property." She then explained the facility determines if a resident was an elopement risk by observing for exit seeking behaviors. She revealed resident #8 attempted to leave the property 2-3 weeks ago. She stated resident #8 was outside walking in the driveway, but was not off the property. The ED stated at that point staff were re-directing her and checking on her frequently. She also stated that the facility kept pictures of all residents and explained the elopement procedure to include searching for the resident, and that staff were to notify her and then the family. The ED stated if residents were not found, staff would contact the police and provide them a picture identification and a face sheet with a list of the "missing resident's" medications.

An interview was conducted with the licensed practical nurse (LPN), Staff F, on at 2:30 pm. She stated that every time the front door opens the door beeps. Staff F, then stated the last time Resident #8 went to the parking lot, she went out front and the resident was already going in a side door. She was then asked, "Do you feel the resident could function alone outside without supervision"? Staff F stated, "No she is too it would be unsafe for her".

The evening LPN, Staff G, was also interviewed on at 2:30 pm. He explained the procedure followed for elopements and stated the last drill was in 2017. He then stated Resident #8 was checked hourly.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967417	03/07/2018
NAME OF PROVIDER OR SUPPLIER **BEACON AT GULF BREEZE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **4410 GULF BREEZE PARKWAY GULF BREEZE, FL 32563**	

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

An interview was conducted with an evening resident assistant ( ), Staff C, on at 5:01pm. She was asked if there had been any elopements. She stated, "Yes", Resident #8 "walked across the street and we went and got her. It happened sometime in ."

Staff D, , was interviewed on at 5:10 pm. She stated there had been an elopement a couple of months ago. She identified Resident #8 as the resident that had eloped. Staff D stated resident #8 left the grounds and staff had to go get her.

On at approximately 5:00pm, an observation was made of resident #8 in the dining with three other residents. On staff indicated resident #8 was out of the building with her son for a medical appointment.

A record review for Resident #8 revealed a resident health assessment for assisted living facilities (1823) dated by a physician on . The resident had diagnosis of a and . behavior status was . There were no listed precautions. It indicated the resident was independent for ambulation.

A nurses' note for resident #8 dated at 2:00 pm written by Employee L, LPN stated, "Resident found off campus 3/4 mile down highway 98 on the south side of the highway. Resident crossed both lanes. coming on shift noted resident with two police officers. Witness driving down highway notified police." According to the note, when Employee L, LPN, approached the resident, she was unaware of any dangers of the busy highway, being out of the community, and was at normal base line of . Employee L wrote that resident #8 was escorted back to the facility without incident and placed on 30 minute checks. The resident's power of attorney (POA) was notified of the incident a request was made to have resident moved to memory care due to safety reasons. Advised son she may need to have a physician review medications to help with transition. Monitoring closely. Observed continued notes through by staff from until .

Note: Highway 98 is a busy 4 lane highway. The resident was found on the south side of the highway which meant she crossed 4 lanes of traffic.

A follow up interview was conducted with the Executive Director on at 10:43 am. She was asked "What happened when the police called you regarding Resident #8 being off campus"? She stated, "No the police did not call us. Resident #8 was seen by an oncoming staff member. She was down the road. We took cars to bring her back. She was about an eighth of a mile from the facility." She was then asked if an adverse incident was completed and she stated, "No. When this happened I

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967417	**03/07/2018**
NAME OF PROVIDER OR SUPPLIER **BEACON AT GULF BREEZE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **4410 GULF BREEZE PARKWAY** **GULF BREEZE, FL 32563**	

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

immediately called corporate who told me it was not considered an elopement since she was in assisted living not memory care." She then said this happened a few months ago early , or the end of . She was asked, "Was the resident in danger". She stated, "Yes she was in danger crossing the highway." We started her on 30 minute checks and she had a sitter for a while. She was checked round the clock for about two weeks. She was asked if there were any other elopements by Resident #8 and she stated, "No, she had had no more elopements. We did find her in the driveway about 3 weeks ago. I am not sure if frequency of checks were increased since there are no notes since ." The ED was asked again about keeping the resident safe and was asked if the staff ensured that resident #8 had identification on her person that would have her name, facility name, and telephone number. She stated, "No, we cannot do that, corporate said that is a violation of HIPPA (Health Insurance Portability and Accountability Act)."

A review of the facility's elopement policy and procedure was reviewed. The policy titled, "SRI Management, LLC Health Management Policy number 3.05 Subject: Wandering and or Elopement Residents" Effective Date , 2016 read:
I. Purpose to identify residents who are at risk for harm because of wandering and /or elopement.
II. The policy is to be followed when a resident has been identified or observed as a risk for wandering and or elopement by using the Resident Service Evaluation. Every effort will be made to prevent and track wandering residents while maintaining the least restrictive environment.
III. Definition- Elopement is defined when a resident leaves the community property beyond the perimeter of the parking lot who have not verbally informed the community of their plans for returning to the community or have not signed out.
: Procedure: 1. Residents who are at risk for harm because of wandering and or elopement will be evaluated at the time of admission as defined in the resident care and service evaluation. 2. The ED and Director of Resident Services will re-evaluate the resident to determine what changes have occurred that would trigger elopement episodes. 3. If the resident's condition has changed since their initial admission to the community the services to be provided will be modified to reflect that the resident has been identified as a wanderer and/or is at risk for elopement episodes.

Class II

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation of the medication carts, staff interview, and review of the medication administration record (MOR) the facility failed to dispose of expired medications for 1 of 4 residents checked (#6).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967417	03/07/2018
NAME OF PROVIDER OR SUPPLIER **BEACON AT GULF BREEZE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **4410 GULF BREEZE PARKWAY GULF BREEZE, FL 32563**	

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

The findings were:

On at 10:30 am, the medication cart for Staff A, a med tech was observed. A bottle of medication found inside the cart, 5 mg (milligram) one by mouth daily, had an expiration date of . (Photographic evidence obtained). The medication was prescribed for resident #6.

The medication bottle was shown to Staff A, med tech, at 10:37am on . Staff A stated, "No I did not notice it was expired." She said, she had assisted with the medication for the resident that morning. A review of the MOR showed resident #6 had been given the medication every day that month.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation of lunch and dinner meals the in memory care unit, staff interview and record review, the facility failed provide timely assistance with meals for 3 of 5 residents observed (#1, #4, and #5) for lunch and 3 of 4 residents for dinner (#1, #4 and #5).

The findings were:

The memory care unit was staffed with 4 resident assistants ( ), which included 1 agency staff, and there was 1 licensed practical nurse . During meals there was one additional dining person who helped serve plates. There were total 38 residents in the memory care unit.

On at 11:00 am, the lunch meal was observed to be starting in the memory care dining . 5 residents were observed to be sitting at a long table in the back of the dining . A plate of food was placed on the table out of the residents reach for each. At 11:10 am, 2 staff members started to assist resident #2 and #3 with their meals while residents #1, #4, and #5 sat at the table waiting to be served. The 3 residents plates remained in the center of the table (#1, #4, #5). During the meal both RAs were observed to stop assisting resident #2 and #3 twice to pull residents #2 and #4 back up in their wheelchairs. At 11:25am, a began to assist resident #1. At 11:30am, a began to assist resident #4. While waiting for assistance with her meal, resident #5 was observed to be sleeping at the table in her wheelchair. At approximately 11:40am, a 3rd reheated resident #5's food which had sat on the table for at least 30 minutes and began to assist her with her meal. Resident #5 appeared to still be sleepy and ate very little of the meal that the was attempting to assist the resident with .

On at 12:16pm, Staff H ( ) was interviewed. She stated that staff started bringing residents

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967417	03/07/2018
NAME OF PROVIDER OR SUPPLIER **BEACON AT GULF BREEZE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **4410 GULF BREEZE PARKWAY GULF BREEZE, FL 32563**	

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

into the dining 10:30am to 10:45am for lunch. Staff H stated that the 5 residents requiring assistance with meals were all sat at the same table and that there were two RAs to assist 5 residents. She stated, "we assist them as soon as we can". When asked about resident #5 having to wait a long time for assistance with meals, Staff H replied, "No I do not think you should have to wait that long to eat."

On at 3:35 pm, residents were observed being placed in the dining dinner by staff. The dinner meal was scheduled to start at 4:00pm. During this meal observation, residents #1, #2, #4, and #5 were observed again to be sitting at a back table in the dining . The Director of Nursing (DON) and Executive Director (ED) were in the dining this surveyor's observation. Both the DON and ED assisted with serving residents their plates. Resident #2 was a immediately assisted with her meal at 4:00pm by a family member at another table. Residents #1, #4, and #5 continued to sit at the table waiting for staff to assist them. At 4:31pm, resident #5 was observed to be leaning over to the right side in her wheelchair sleeping. Following resident #5's observation, staff K was interviewed and she revealed the resident's , and , medications were being held due the resident sleeping a lot. Staff K indicated this was the 2nd night resident #5's medication had been held. Resident #5 was taking to her put to bed without eating during the meal time. The DON assisted resident #4 at 4:38 with eating her meal; resident #1 still sat at the table waiting to be assisted. At 4:47pm, a assisted resident #1 with her meals.

An interview was conducted with the ED and the DON on at 5:33 pm. The DON stated, "We are trying to find a solution for dining in the memory care. We want to put one or 2 feeders with prompters at different tables". The ED changed the to "people who need assistance." The ED and DON were asked, "Should any resident be required to sit at a table while others are being assisted with eating and wait for 40 minutes to get assistance? The ED stated, "No, we have a higher acuity level back there maybe we need more staff? We have lot of people who need assistance with dining." She was then asked "Were there enough staff to assist with dining and eating today for the residents in memory care. She stated, "No".

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review, staff interview the facility failed to complete and submit an adverse incident report for 1 of 1 (#8) resident that eloped and was at risk of harm or injury.

The findings were:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967417	03/07/2018
NAME OF PROVIDER OR SUPPLIER **BEACON AT GULF BREEZE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **4410 GULF BREEZE PARKWAY** **GULF BREEZE, FL 32563**	

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

A record review for Resident #8 revealed a resident health assessment for assisted living facilities (1823) dated by a physician on . The resident had diagnosis of a and . behavior status was . There were no listed precautions. It indicated the resident was independent for ambulation. A nurses' note for resident #8 dated at 2:00 pm written by Employee L, LPN stated, "Resident found off campus 3/4 mile down highway 98 on the south side of the highway. Resident crossed both lanes. coming on shift noted resident with two police officers. Witness driving down highway notified police." According to the note, when Employee L, LPN, approached the resident, she was unaware of any dangers of the busy highway, being out of the community, and was at normal base line of . Employee L wrote that resident #8 was escorted back to the facility without incident and placed on 30 minute checks. The resident's power of attorney (POA) was notified of the incident a request was made to have resident moved to memory care due to safety reasons. Advised son she may need to have a physician review medications to help with transition. Monitoring closely. Observed continued notes through by staff from until .

On at 2:07 pm, an interview was conducted with the Executive Director (ED). She was asked if the facility had any elopements in the past six months. She stated, "No, we have not had any elopements off the property." She then explained the facility determines if a resident was an elopement risk by observing for exit seeking behaviors. She revealed resident #8 attempted to leave the property 2-3 weeks ago. She stated resident #8 was outside walking in the driveway, but was not off the property. The ED stated at that point staff were re-directing her and checking on her frequently. She also stated that the facility kept pictures of all residents and explained the elopement procedure to include searching for the resident, and that staff were to notify her and then the family. The ED stated if residents were not found, staff would contact the police and provide them a picture identification and a face sheet with a list of the "missing resident's" medications.

An interview was conducted with the licensed practical nurse (LPN), Staff F, on at 2:30 pm. She stated that every time the front door opens the door beeps. Staff F, then stated the last time Resident #8 went to the parking lot, she went out front and the resident was already going in a side door. She was then asked, "Do you feel the resident could function alone outside without supervision"? Staff F stated, "No she is too it would be unsafe for her".

The evening LPN, Staff G, was also interviewed on at 2:30 pm. He explained the procedure followed for elopements and stated the last drill was in 2017. He then stated Resident #8 was checked hourly.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967417	**03/07/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON AT GULF BREEZE (THE)	**4410 GULF BREEZE PARKWAY GULF BREEZE, FL 32563**

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

An interview was conducted with an evening resident assistant ( ), Staff C, on at 5:01pm. She was asked if there had been any elopements. She stated, "Yes", Resident #8 "walked across the street and we went and got her. It happened sometime in ."

Staff D, , was interviewed on at 5:10 pm. She stated there had been an elopement a couple of months ago. She identified Resident #8 as the resident that had eloped. Staff D stated resident #8 left the grounds and staff had to go get her.

On at approximately 5:00pm, an observation was made of resident #8 in the dining with three other residents. On staff indicated resident #8 was out of the building with her son for a medical appointment.

A follow up interview was conducted with the Executive Director on at 10:43 am. She was asked "What happened when the police called you regarding Resident #8 being off campus"? She stated, "No the police did not call us. Resident #8 was seen by an oncoming staff member. She was down the road. We took cars to bring her back. She was about an eighth of a mile from the facility." She was then asked if an adverse incident was completed and she stated, "No. When this happened I immediately called corporate who told me it was not considered an elopement since she was in assisted living not memory care." She then said this happened a few months ago early , or the end of . She was asked, "Was the resident in danger". She stated, "Yes she was in danger crossing the highway." We started her on 30 minute checks and she had a sitter for a while. She was checked round the clock for about two weeks. She was asked if there were any other elopements by Resident #8 and she stated, "No, she had had no more elopements. We did find her in the driveway about 3 weeks ago. I am not sure if frequency of checks were increased since there are no notes since ."

Class II