Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964649	A. BUILDING: _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE AT AZALEA TRACE	10100 HILLVIEW ROAD PENSACOLA, FL 32514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint survey was conducted at Oakbridge Terrace at Azalea Trace assisted living facility on to review the allegation within complaint #2019009053. Deficient practice was identified at the time of the survey.	A 000		
A 165 SS=D	429.23(&) FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more	A 165		

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A 165	Continued From page 1 acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to	A 165		

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A 165	Continued From page 2 disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. 58A-5.0241 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1) above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to maintain documentation of an investigation and offer staff training on mental health issues for 1 of 1 sampled adverse incidents involving the . . . . . of a resident. (resident #1)	A 165		

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A 165	Continued From page 3 The findings include: Review of resident #1's record revealed a progress note [redacted] at 6:20 AM indicating the Certified Nursing Assistant (CNA) came running to the nurse's station very upset stating you need to come to her room right now. I think she is [redacted]; I think she shot herself in the [redacted]. Upon entering the room the nurse observed resident flat on her [redacted], in her bed, unresponsive with a large amount of [redacted] noted around her [redacted] on her pillow and what appeared to be a gun in her [redacted]. Administration and 911 called. Review of the sheriff's office report obtained by the surveyor, revealed on [redacted] the autopsy report indicated the manner of [redacted] to be [redacted] with cause of [redacted] being a gunshot [redacted] of the [redacted]. An interview was conducted with the facility Administrator on [redacted] at 10:02 AM. He stated the facility did not have documentation of an investigation other than the report submitted to the state agency, the matter was turned over to the police for investigation. He does not have a police report. Further interview was conducted with the Administrator on [redacted] at 10:33 AM. He stated they interviewed the staff about what they saw, when the last time they checked on the resident, if she made any threats and how she was but none of this was documented. He stated no one interviewed housekeeping staff to see if they saw any gun. The daughter was not aware she had a firearm. None of the staff were aware she had a gun. No staff training (such as the signs and symptoms of [redacted] or [redacted]) was completed after the incident. The facility interviewed employee C (licensed practical nurse) and employee D (CNA) and culinary staff that	A 165		

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A 165	Continued From page 4 served her dinner the night before regarding her behavior. No other direct care staff were interviewed regarding her behavior or signs of , , . A telephone interview was conducted with employee C (licensed practical nurse) on at 10:59 AM. She stated the facility asked her what she found at the time of the incident and the resident's behavior prior to the incident. She was not aware of the resident making any statements or change in her behavior. The facility did not provide any training after the incident regarding recognizing signs of , or . A telephone interview was conducted with employee D (certified nursing assistant) on at 10:50 AM. She stated the facility asked her what she found when she went to the resident's room. The facility did not ask her about the resident's behavior prior to the incident. The facility did not provide any training after the incident regarding recognizing signs of , , or . Class III	A 165		