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
	AL11965056	A. BUILDING: _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF FT. MYERS	15950 MCGREGOR BLVD. FORT MYERS, FL 33908

(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
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [illegible] are enrolled in the national retained print [illegible] notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to obtain a level 2 background screening for 1 (Staff C) of 3 staff reviewed with a break in service greater than 90 days, and failed to update the facility roster pursuant to chapter 435 within 10 days of hire for 1 (Independent	CZ814		

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CZ814	Continued From page 1 contractor E) of 1 independent contractor reviewed who provides direct care to the residents. This has the potential for staff with disqualifying offenses to have access to . . . . . adults at their place of residence. The findings included: 1. Independent contractor E is a Registered Nurse employed at the facility as of to oversee and provide limited nursing services to the residents. Review of the facility's roster revealed it was not updated to reflect independent contractor E's employment at the facility. On . . . . . at 10:25 a.m., interview with the Administrator confirmed independent contractor E was not added to the facility roster. She said she wasn't aware of the requirement and will add him to the roster. 2. Review of the personnel file revealed Licensed Practical Nurse (LPN) Staff C began employment at the facility on . . . . Review of the application revealed her last employment ended on . The last background screening was done on . . . . . . There was no documentation the facility obtained a new background screening despite the documented break of employment of greater than 90 days. On at 10:30 a.m., the Administrator verified the facility should have submitted the employee to a new background screening upon	CZ814		

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CZ814	Continued From page 2 hire. Unclassified	CZ814		
A 000	Initial Comments An unannounced relicensure and limited nursing services survey was conducted through at Arden Courts of Ft. Myers, an assisted living facility in Fort Myers, Florida. The following is description of the deficiencies.	A 000		
A 032	58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(i) Resident Care - Elopement Standards 58A-5.0182 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 58A-5.0181(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name,	A 032		

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A 032	Continued From page 3 address, and telephone number. Staff trained pursuant to paragraph 58A-5.0191(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(l), F.S. 429.41(1)(a)3 & 3(l),FS	A 032		

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A 032	Continued From page 4 3. Resident elopement requirements.-Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures. (I) The establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills. Facilities shall document the drills. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 1 (Resident #13) of 1 resident who was identified as an elopement risk had identification on his person and failed to ensure additional steps were taken to ensure that Resident #13 did not elope again, after he eloped on two separate occasions. The findings included: Record review on at 3:00 p.m., revealed Resident #13 had no added notes to his service plan or orders to alert all staff of his history of 2 successful elopements. Resident #13's Health Assessment, signed on , indicates the resident is an elopement risk. The facility's elopement policy and procedure (no date or revision date) references what is done during an elopement of missing resident and immediately after resident is found. No reference	A 032		

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A 032	Continued From page 5 is made to the assessment for elopement risk or added monitoring after an elopement. On at 4:15 p.m., the Administrator recounts the 1st incident that Resident #13 successfully eloped from the facility was on . . . . . She said they were having issues with the alarm. The alarm was going off and they couldn't figure out why. The doors were still secured. She called the company and they came out. She spoke to the technician who said he will test the doors now. She let the staff know and had someone at the doors. They assigned an individual to the doors. By the time the care giver went to the assigned door, it was already opened. The Administrator ordered a search of the building to see if all residents were still there and realized Resident #13 was gone. They initiated their policy and called law enforcement who said they had already gotten a call from the gas station about 2 miles down the road and they think it may be him. The Administrator said the 2nd incident was on . . . . . She said she was on vacation when she got the call from the facility. She was informed that a staff member leaving work after 8:00 p.m., found Resident #13 and a female resident with a walker outside in the parking lot by the dumpster. She said that staff got the two residents into the facility and put Resident #13 on 30 minute checks for 24 hours. The Administrator said that all residents in the facility are checked hourly and this hourly check procedure was in place before Resident #13 eloped. The Administrator said the residents must have left between 7:45 p.m. and 8:05 p.m. The Administrator acknowledged the facility is a secure building with coded locks on every door. She stated, "we still do not know how they got out."	A 032		

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A 032	Continued From page 6 The Administrator said when she came . . . from vacation, she sat with the employees and had them tell her what happened, and she got their statements. She said she did not write down her investigation. After this she said she changed the door code on the kitchen and the main doors. She went through the visitor log for the night of the elopement. She found a family member of another resident had come in at 7:45 p.m., but this family member never signed out. She did not call this family member to find out what time she left and if anyone followed her. On at 5:40 p.m., the Administrator said the facility has not made any effort to ensure each resident who is at risk for elopement maintain an identification on their person. She said she wasn't aware of the regulation. She said Resident #13 is certainly the most challenging resident in the building and is the only one at risk for elopement. During a second interview on . . . . . at 11:30 a.m., the Administrator said the only thing they do to try to distract Resident #13 from wanting to get out and go is they put him in charge of projects. He is a . . . . . and sometimes it is difficult to be with him all the time. She said the interventions are not recorded anywhere to alert the staff. She said she spoke to the nursing director and the activity director to tell them to keep Resident #13 engaged in activities but she didn't document it. She said she spoke with the department heads at stand up meeting and told them they needed to do anything they can to keep him busy to prevent elopement. The Administrator agreed the facility did not update the care plan and implement individualized interventions to keep the resident at risk for elopement and exit seeking safe from further	A 032		

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A 032	Continued From page 7 elopement. On . . . . . at 11:50 a.m., Staff F, a resident care assistant, said Resident #13 is everywhere walking around. He tries to leave the facility a lot. She just tries to bring him to activities. Sometimes he gets very aggressive and cannot be redirected. When this happens, she lets him do whatever he wants to do. He needs more attention when he's acting like that but it's all the time, even at night. She said everyone watches after him. Sometimes he walks around a lot with another resident. He is always looking for his truck and wants to go to the parking lot. On at 11:55 a.m., Staff G, a resident caregiver, said she walks with Resident #13 a lot, gives him snacks, and engages him in activities. She said there is nothing different in the way they supervise him from other residents. He likes to talk a lot about his car so she listens to him. He walks around all the time and goes outside all the time. He pushes the doors. She said he is free to walk outside but there is not always someone with him. He is on hourly check but so are all the residents. She said he just loves to chat so she talks to him to keep him inside. On . . . . . at 12:01 p.m., Staff C, a licensed practical nurse, said right now Resident #13 is on hourly check just like everyone in the building. There is no other intervention for him. He . . . . . around everywhere, the whole facility. He is not always exit seeking but he frequently goes to the courtyard. He never verbalizes that he wants to leave. He just walks around. She said all the doors are opened to the courtyard and he can go outside. Staff monitor the courtyard every 15 minutes but the residents can be left unsupervised outside.	A 032		

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A 032	Continued From page 8 Class II	A 032		