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
	AL11968426	A. BUILDING: _____ B. WING _____	09/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA COLONIA II ALF INC	637-639 SE 12TH CT CAPE CORAL, FL 33990

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A 000	Initial Comments An unannounced complaint survey for #2019013805 was conducted on . . . through at La Colonia II, an assisted living facility in Cape Coral, Florida. Complaint #2019013805 was substantiated with Class I deficiencies identified at A0025 Supervision and A0032 Elopement Procedures. The following is a description of the Class I deficiencies.	A 000		
A 025	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of . . . . . or . . . . . or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such . . . . . or . . . . . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C.	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interviews, observation, and record review, the facility failed to provide the supervision required for being a "flight risk" (elopement risk) to 1 (Resident #1) of 5 residents sampled; Failed to notify staff of the elopement status of Resident #1; and Failed to ensure the building was secure for a resident identified as an elopement risk. Failure to provide supervision lead to the resident leaving the facility unsupervised and [redacted] lost for approximately 30 hours. The findings included: 1. A review of Resident #1's record showed a progress note on [redacted] he was missing from the facility. He was last seen at 4:00 a.m. At 5:01	A 025		

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A 025	Continued From page 2 a.m. the staff notified the administrator and police Resident #1 was not in the facility. He was found by the police and returned to the facility at 11:00 a.m. on . Resident #1 was missing from the facility from at approximately 5:00 a.m. to at 11:00 a.m., approximately 30 hours. A review of Resident #1's health assessment dated showed he was documented as a "flight risk" by the physician. On at 1:15 p.m., during interview Resident #1 said he "took a walk" and then came home. Further questioning by the surveyor revealed Resident #1 had little recall of elopement events. On at 1:20 p.m., observation showed Resident #1 did not have any identification on his person. At that time on , Consultant Staff A confirmed Resident #1 still did not have any identification on his person. On at 1:56 p.m., during interview Resident #1's doctor said Resident #1's wife told him when she leaves her house and leaves her husband home alone, her husband (Resident #1) will away from the home. He requires 24/7 supervision. On at 1:50 p.m., during interview Consultant Staff A said she was aware Resident #1 was an elopement risk and ordered a for him, but it had not been received yet. At 2:00 p.m. she said when Resident #1 eloped from the facility, she thought the staff, who was working at that time, might have been sleeping, but she was not sure. She said at the time of Resident #1's elopement there was one staff working at night. She verified staff were allowed to sleep when residents are asleep. Consultant Staff A said each front door had an alarm on it. She thought the alarm for 639's front door was	A 025		

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A 025	Continued From page 3 either not working or the volume was too low. She also said there were no other interventions put in place to ensure Resident #1 had the appropriate supervision to keep him safe in the facility. On at 2:00 p.m., observation revealed the facility is a remodeled duplex with two front doors beside each other. The facility retained both postal address numbers 637 and 639.) On . . . . at 1:30 p.m., the detective assigned to this case said the facility notified the police on . . . . at 7:24 a.m. Resident #1 was missing. Resident #1 was found on at 9:40 a.m. at a park 2.7 miles from facility. The detective said Resident #1 was disoriented, his clothes were wet, and he had a few scratches on him as if he went through some bushes but, no other obvious physical injuries. Class 1	A 025		
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	A 032		

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A 032	Continued From page 4 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, 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	A 032		

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A 032	Continued From page 5 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 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. (l) 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: A0032 Based on interviews, observation and record review, the facility failed to put in place the appropriate interventions for 1 (Resident #1) of 1 resident who was identified as a "flight risk." Failure to implement the Elopement protocol lead to the resident leaving the facility unsupervised and ˬ lost for approximately 30 hours. The findings included: 1. A review of Resident #1's record showed he	A 032		

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A 032	Continued From page 6 was admitted to the facility on . . . A progress note was written on he eloped from the facility. He was last seen at 4:00 a.m. At 5:01 a.m. the staff notified the administrator and police that Resident #1 was not in the facility. He was found by the police and returned to the facility at 11:00 a.m. on . . . A review of his health assessment dated showed it was written in that he was a "flight risk," and has a diagnosis of "memory , ." On at 1:56 p.m., during interview Resident #1's doctor said Resident #1's wife told him when she leaves her house and leaves her husband home alone, her husband (Resident #1) will away from the home. He requires 24/7 supervision. On . . . , at 1:10 p.m., observation of the facility and area surrounding the facility revealed the facility is located in a neighborhood on a side street off a main road. Traffic flow was observed to be minimal on the side street the facility is located on but is much busier on the 4 main streets ringing the facility. The facility is located within walking distance from Viscaya Parkway, Del Prado Boulevard, Cultural Park Boulevard, and Hancock Bridge Parkway. These areas are crossed with canals and lakes and water retention ponds. Interview on at 1:30 p.m., with the police detective revealed Resident #1 was found by the police at a park which was approximately 2.7 miles from the facility. The detective said Resident #1 was disoriented, his clothes were wet, and he had a few scratches on him as if he went through some bushes but, no other obvious physical injuries. Observation of the area revealed Resident #1 would have had to walk either through neighbor's yards or side streets and around canals and/or ponds to get to	A 032		

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A 032	Continued From page 7 a park. On . . . . at 1:15 p.m., during interview Resident #1 said he "took a walk" and then came home. Further questioning by the surveyor revealed Resident #1 had little recall of elopement events that had ended just that morning when the police located him at 9:40 a.m. and returned him to the facility at 11:00 a.m.. On at 1:30 p.m., the detective assigned to this case said the facility notified the police on . . at 7:24 a.m. Resident #1 was missing. Resident #1 was found on . . . . at 9:40 a.m. at a park 2.7 miles from facility. The detective said Resident #1 was disoriented, his clothes were wet, and he had a few scratches on him as if he went through some bushes but, no other obvious physical injuries. On at 1:20 p.m., observation showed Resident #1 did not have any identification on his person. At that time on , Consultant Staff A confirmed Resident #1 still did not have any identification on his person. On at 1:50 p.m., during interview Consultant Staff A said she was aware Resident #1 was an elopement risk and ordered him a . . . . . for identification, and verified he had no identification on him at the time of this incident. She said it would be delivered to the facility on . Consultant Staff A also said she did not put any other interventions in place for proper supervision to keep him from eloping from the facility. She verified staff were allowed to sleep at night, the alarms on the doors were not checked, staff were not notified of Resident #1 being a "flight risk" and staff were not told he required direct supervision.	A 032		

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A 032	Continued From page 8 Class 1	A 032		