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
	AL11964922	A. BUILDING: _____ B. WING _____	R 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING OF PALM BEACH	4760 JOG ROAD GREENACRES, FL 33467

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{A 000}	Initial Comments An unannounced revisit to the licensure complaint survey, #2019003960, #2019004627, #2019005643, #2019005968 and #2019006499, was conducted on [redacted] and [redacted] at Pacifica Senior Living of Palm Beach. The facility had an uncorrected deficiency and a new deficiency identified at the time of the survey.	{A 000}		
{A 032} SS=D	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, 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.	{A 032}		

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{A 032}	Continued From page 1 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 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	{A 032}		

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{A 032}	Continued From page 2	{A 032}		

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:
Based on observation, review and interview, the facility failed to ensure that proper/or adequate staff attention was directed toward residents at high risk for elopement, with special attention given to those with 's or related assessed at high risk, for 1 out of 3 sampled residents (Resident #1).

Findings Include:

Review of confidential records on at approximately 10:00 AM, revealed Resident #1 eloped from the facility on , sometime after 11:00AM. Resident #1 was last seen at approximately 11:00 AM in Cottage#7 by Staff A. Resident#1 was located at approximately 2:00PM, at the guard gate to his son's living community, which is located 28 miles from the facility in Delray Beach. The son notified the facility, and Resident#1 was returned to the facility at approximately 3:00PM.

Review of the Adverse Incident Day 1 reports submitted on at 10:48 AM revealed, the agency requested additional information on . The facility submitted the full report

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{A 032}	Continued From page 3 on . . . . . and the agency requested more information on . As of , the 15-day full report has not been completed due to requested information not submitted. Review of Resident #1's file revealed the "Narrative Charting" documents. This surveyor observed an entry for Resident#1 on at 3:35PM, and stated the resident was missing for 3 ½ hours and was returned by the daughter. At this time, the facility was unable to provide any additional documentation regarding the incident. There was also no report from the local County law enforcement agency involved with the incident. Review of Resident#1's file revealed an admission date of . Resident #1's Agency for Healthcare Administration Health Assessment (AHCA form 1823) dated revealed the resident suffers from . . . . . , history of ( ), A fib (. . . . .) and has difficulty walking. The form does not document the resident as an elopement risk (Elopement Risk box was checked "No"). In addition to documenting Resident#1 was not an elopement risk, it also stated Resident #1 was alert and oriented to self, with short- and long-term memory . . . . and was at risk for . During an interview with Staff A on at 11:21 AM, the following was revealed. According to Staff A on the day of the incident, the resident resided in Cottage#7; census at that time was 13. The facility had 1 direct care staff member and 1 Med Tech that floated throughout the cottages on duty; as Cottage #7 houses the residents that are identified as higher functioning residents. The incident occurred during preparation for lunch.	{A 032}		

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{A 032}	Continued From page 4 Staff A stated she saw Resident#1 at breakfast and last saw him during snack time at 11:00AM. Staff A prepared lunch and when she went to get Resident#1 from his room he was not there. Staff A looked outside and did not see him. Staff A immediately notified the front desk that Resident#1 was missing. Staff A and additional staff looked inside and outside of the property and could not locate Resident#1. Resident#1's family was notified, and local law enforcement was notified. Staff A stated Resident#1 was returned to the facility at approximately 3:00PM, as he was leaving for the day. Staff A stated on the next day on , as she was outside with Resident#1, he made the comment " oh they fixed the gate so I can't crawl under it anymore". On at 11:34 AM, during a telephone interview with Resident#1's family, he stated he received a phone call on at around 12:00 PM (exact time not remembered); he was notified that his father had eloped from the facility. He stated he notified his community guard gate to be on alert as he believed that is where his father was going to go. He stated he received a call at approximately 1:45 PM from his community guard gate to say his father was there. He stated he immediately went home (which was 15 minutes away), gave his father lunch and he returned him to the facility at approximately 3:00 PM. He stated he believed his father took the bus from the facility, to the Tri- Rail Station (which is about 15 minutes from his house). He stated when he arrived, he was not injured but did have dirt on his clothes as if he had been on the ground. He stated he made the facility aware on admission that Resident#1 was obsessed with returning to his son's house to retrieve documents he believes he left there. He also stated Resident#1 stated, he crawled under a fence to elope from	{A 032}		

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{A 032}	Continued From page 5 the facility. The facility failed to ensure that staff's attention was directed toward residents at high risk for elopement, with special attention given to those with or related assessed at high risk. Class III Uncorrected	{A 032}		
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	A 165		

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A 165	Continued From page 6 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 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,	A 165		

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A 165	Continued From page 7 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 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 review and interview, it was	A 165		

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A 165	Continued From page 8 determined the facility failed to ensure that the 1-day report (preliminary report) and 15-day report (full report) are submitted to the Agency for Health Care (AHCA) in its entirety and any additional information required by ACHA is submitted timely. The findings included: Review of confidential records on at approximately 10:00AM, revealed Resident #1 eloped from the facility on , sometime after 11:00AM. Resident #1 was last seen at approximately 11:00AM in Cottage#7 by Staff A. Resident#1 was located at approximately 2:00PM, at the guard gate to his son's living community, which is located 28 miles from the facility in Delray Beach. The son notified the facility, and Resident#1 was returned to the facility at approximately 3:00PM. During an interview with Staff A on at 11:21 AM, the local police was contacted. Review of Resident #1's record revealed a diagnosis of . Therefore, the elopement places the resident at risk for harm and injury. Review of the Adverse Incident Day 1 reports submitted on at 10:48AM revealed, the agency requested additional information on . The facility submitted the full report on and the agency requested more information on . As of , the additional information requested by AHCA based on the submitted 1 day and 15 day report has not been received. Class III	A 165		

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