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
	AL11968119	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT IVEY ACRES OF JAY	3964 FLORIDA AVE JAY, FL 32565

(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 (2020001469) was conducted at The Terrace at Ivey Acres of Jay Assisted Living Facility on . At the time of survey the allegations were substantiated with deficiencies cited at Class 1. Class I deficiencies were identified on , , A0025 Resident Care - Supervision and A0032 - Resident Care - Elopement Standards for the facility's failure to ensure resident's at risk for elopement were identified and steps were put into place to prevent residents were leaving the building unattended. The facility Administrator was notified of the Class I deficiencies , . At the time of the survey, the facility census was 52.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(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. 59A-36.007 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	A 025		

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A 025	Continued From page 1	A 025		

supervision as appropriate for each resident, including the following:
(a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C.
(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 interview and record review, the facility failed to maintain general awareness and whereabouts of 1 of 4 sampled resident's (#1) resulting in an elopement from the facility.
The facility's failure to ensure the resident was assessed for elopement risks and failure to effectively supervise the resident resulted in staff being unaware of the elopement of Resident #1 on when identified by law enforcement.
These failures resulted in the a Class I deficiency.
The Administrator was notified of the Class I

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A 025	Continued From page 2 deficiency on . . . . . . The findings include: On . . . . . at approximately 1:20 PM via telephone interview with employee A, Medication Technician/Patient Staff Assistant, the employee reported that on she and employee B, a Patient Staff Assistant, were in the kitchen cleaning and filling condiments while resident #1 was sleeping on sofa in the living room. She stated that both employees stepped outside to receive coffee from an off duty co-worker. Employee A reported that while they were outside, they observed the facility van leaving the parking lot and they did not know who was driving. Employee A, reported that they thought someone had stolen the van and did not know at the time that it was resident #1. She stated that employee B stayed outside and watched to see which way the van turned out of the driveway and while she ran into the facility to call 911. Employee A, reported that she did not know how and when resident #1 got out of the facility. Employee A reported that they did not know it was resident #1 until they arrived at the area where the van was found about a quarter mile down the road from the facility by law enforcement. A review of the police report indicated that the officer responded to the call from the facility in reference to a stolen vehicle complaint. Dispatch advised that the employees at the facility had witnessed an unknown subject drive east on Florida Ave. The officer found the white Dodge transport van in the grass on the north side of the road. The van appeared to be stuck. However, the reverse lights were on, and someone was trying to the van up. The officer immediately noticed the driver, later identified as resident #1,	A 025		

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A 025	Continued From page 3 seemed very . . . . . The report indicated that another officer arrived on the scene and both officers approached the van. Resident #1 had his on the steering wheel, so the officer opened the door, placed the vehicle in park, and then assisted resident #1 out of the van and escorted him to the patrol car and had him sit in the seat. The report indicated that the officer spoke with resident #1 who was . . . . . and could not give officer his full name or date of birth. The report indicated that the resident reported that he had woke up and walked into his front yard. Once in the yard, he noticed the van, so he went for a drive. The report indicated that the officer asked the resident if he knew where he was or where he planned to go, and resident could not say. At this point, employees A and B, arrived on the scene. They were asked if the driver of the van was a resident of their facility. Employees A and identified the driver as resident #1 informing officer that he had . The report indicated that employee B took resident #1 . . . . to the facility and employee A took possession of the van. On at approximately 9:48 AM, an interview was conducted with the Administrator who reported that she received a telephone call from the facility about 3:30am on . . . . , stating someone had stolen the lift van, and that employee A and B had already called 911. She further reported she arrived within 15 minutes. When she arrived at the facility resident #1 and van were at the facility. She spoke with law enforcement who informed her that they found resident #1 and the van about a quarter mile down the road right off the edge. The deputy informed her when he approached the van, resident #1 had the van in reverse and when officer asked resident where he was going, the	A 025		

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A 025	Continued From page 4 resident stated that he was going home. The Administrator reported at the time that the resident was calm, and appeared fine so she contacted the resident's nephew/power of attorney and informed him of the incident. She reported they reviewed the video surveillance footage and observed resident #1 walked to the door with no assistance, turned the doorknob and the door popped open. She was unable to report why the door was unlocked. She further reported that the keys were left in the van in the cup holder. She stated that at the time the resident left the building both staff members (A and B) were in the dining room mopping the floor. The administrator reported that resident #1 had and was not aware of safety. She reported that she had not submitted an initial adverse incident report to the agency, and that while there had been an elopement drill in there had not been education or drills since the incident. A record review was conducted of facility's elopement drill log which indicated the last elopement drill was . A record review was conducted of facility's Elopement/Missing Resident policies and procedures. It is the policy of the facility to provide a safe and secure environment for our residents. For the requirement of reporting all resident's elopement to the state via and Adverse Incident report, the following is the definition of resident elopement: 1. When a resident has left the building unescorted without staff knowledge. (9) If it is an actual elopement, notify the state officials (to be performed by Executive Director/Resident Care Director), must notify state agency within 24 hours of event or as per	A 025		

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A 025	Continued From page 5 state requirements. (13) when the resident is located document situation and resident condition (15) Begin investigation as to the casual factor of elopement, summarize findings and new interventions and send to state officials as required by state rules and regulations. Executive Director/Resident Care Director to perform Class I	A 025		
A 032 SS=J	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (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 59A-36.006(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 59A-36.011(10)(a) or (c),	A 032		

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A 032	Continued From page 6 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. This Statute or Rule is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure staff received training on	A 032		

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A 032	Continued From page 7 the facility's policies and procedures related to resident elopement and conduct elopement drills. The facility's failure to ensure staff were able to demonstrate competency in the implementation of the elopement response policies and procedures resulted in the a Class I deficiency. The Administrator was notified of the Class I deficiency at . The findings included: On at approximately 9:48 AM, an interview was conducted with the Administrator who reported that she received a telephone call from the facility about 3:30am on , stating someone had stolen the lift van, and that employee A and B had already called 911. She further reported she arrived within 15 minutes. When she arrived at the facility resident #1 and van were at the facility. She spoke with law enforcement who informed her that they found resident #1 and the van about a quarter mile down the road right off the edge. The deputy informed her when he approached the van, resident #1 had the van in reverse and when officer asked resident where he was going, the resident stated that he was going home. The Administrator reported at the time that the resident was calm, and appeared fine so she contacted the resident's nephew/power of attorney and informed him of the incident. She reported they reviewed the video surveillance footage and observed resident #1 walked to the door with no assistance, turned the doorknob and the door popped open. She was unable to report why the door was unlocked. She further reported that the keys were left in the van in the cup holder. She stated that at the time the resident left the building both staff members (A and B) were in the dining room mopping the floor. The	A 032		

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A 032	Continued From page 8 administrator reported that resident #1 had and was not aware of safety. She reported that she had not submitted an initial adverse incident report to the agency, and that while there had been an elopement drill in there had not been education or drills since the incident. A record review of the facility's elopement drill log indicated the last elopement drill was conducted on . A record review was conducted of seven (7) employee's personnel files for elopement training before and after elopement for resident #1 on 1. Employee A Medication Technician/Patient Staff Assistant, hire date no elopement training before or after elopement. 2. Employee B Patient Staff Assistant, hire date unknown, no elopement training before or after elopement. 3. Employee D Med Tech/Patient Staff Assistant, hired elopement training , no elopement training after the incident. 4. Employee E, Housekeeping, hired no elopement training before or after elopement. 5. Employee F, Med Tech/Patient Staff Assistant, hired no elopement training before or after elopement. 6. Employee F, Licensed Practical nurse/Resident Care Director, hired , no elopement training before or after elopement. Class 1	A 032		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report	A 165		

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A 165	Continued From page 9 429.23 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 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	A 165		

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A 165	Continued From page 10 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) [redacted], neglect, or [redacted] 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 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.	A 165		

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A 165	Continued From page 11 (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 agency may adopt rules necessary to administer this section. 59A-36.016 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 interview and record review, the facility failed to submit an initial adverse incident report within 1 business day of an elopment and a full adverse incident report within 15 days of the elopement for 1 of 1 resident(#1). The findings included: A review of the police report regarding resident #1 indicated that on an officer responded to the call from the facility in reference to a stolen vehicle complaint. Dispatch advised that the employees at the facility had witnessed an unknown subject drive east on Florida Ave. The	A 165		

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A 165	Continued From page 12	A 165		

officer found the white Dodge transport van in the grass on the north side of the road. The van appeared to be stuck. However, the reverse lights were on, and someone was trying to the van up. The officer immediately noticed the driver, later identified as resident #1, seemed very . . . . . The report indicated that another officer arrived on the scene and both officers approached the van. Resident #1 had his . . . on the steering wheel, so the officer opened the door, placed the vehicle in park, and the assisted resident #1 out of the van and escorted him to the patrol car and had him sit in the . . . seat. The report indicated that the officer spoke with resident #1 who was . . . . . and could not give officer his full name or date of birth. The report indicated that the resident reported that he had woke up and walked into his front yard. Once in the yard, he noticed the van, so he went for a drive. The report indicated that the officer asked the resident if he knew where he was or where he planned to go, and resident could not say. At this point, employees A and B, arrived on the scene. They were asked if the driver of the van was a resident of their facility. and they identified the driver as resident #1 informing officer that he had . . . . . The report indicated that employee B took resident #1 to the facility and employee A took possession of the van.

On . . . . . at approximately 9:48 AM, an interview was conducted with the Administrator who reported that she received a telephone call from the facility about 3:30am on , stating someone had stolen the lift van, and that employee A and B had already called 911. She further reported she arrived within 15 minutes. When she arrived at the facility resident #1 and van were at the facility. She spoke with law enforcement who informed her that they found

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A 165	Continued From page 13 resident #1 and the van about a quarter mile down the road right off the edge. The deputy informed her when he approached the van, resident #1 had the van in reverse and when officer asked resident where he was going, the resident stated that he was going home. The Administrator reported at the time that the resident was calm, and appeared fine so she contacted the resident's nephew/power of attorney and informed him of the incident. She reported they reviewed the video surveillance footage and observed resident #1 walked to the door with no assistance, turned the doorknob and the door popped open. She was unable to report why the door was unlocked. She further reported that the keys were left in the van in the cup holder. She stated that at the time the resident left the building both staff members (A and B) were in the dining room mopping the floor. The administrator reported that resident #1 had . . . . . and was not aware of safety. She reported that she had not submitted an initial adverse incident report to the agency, and that while there had been an elopement drill in . . . . . there had not been education or drills since the incident. On at approximately 1:20 PM via telephone interview with employee A, Medication Technician/Patient Staff Assistant, the employee reported that on . . . . she and employee B, a Patient Staff Assistant, were in the kitchen cleaning and filling condiments while resident #1 was sleeping on sofa in the living room. She stated that both employees stepped outside to receive coffee from an off duty co-worker. Employee A reported that while they were outside, they observed the facility van leaving the parking lot and they did not know who was driving. Employee A, reported that they thought someone	A 165		

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
	AL11968119	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 165	Continued From page 14 had stolen the van and did not know at the time that it was resident #1. She stated that employee B stayed outside and watched to see which way the van turned out of the driveway and while she ran into the facility to call 911. Employee A, reported that she did not know how and when resident #1 got out of the facility. Employee A reported that they did not know it was resident #1 until they arrived at the area where the van was found about a quarter mile down the road from the facility by law enforcement. A review was conducted of facility's Elopement/Missing Resident policies and procedures revealed that "It is the policy of the Terrace to provide a safe and secure environment for our residents. For the requirement of reporting all resident's elopement to the state via and Adverse Incident report, the following is the definition of resident elopement: 1. When a resident has left the building unescorted without staff knowledge. (9) If it is an actual elopement, notify the state officials (to be performed by Executive Director/Resident Care Director), must notify state agency within 24 hours of event or as per state requirements. (13) when the resident is located document situation and resident condition (15) Begin investigation as to the casual factor of elopement, summarize findings and new interventions and send to state officials as required by state rules and regulations. Executive Director/Resident Care Director to perform Class III	A 165		