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 |
|---|---|---|---|
| | AL11969434 | A. BUILDING: _____ B. WING _____ | 06/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HARBORCHASE OF WELLINGTON CROSSING | 8785 LAKE WORTH ROAD WELLINGTON, FL 33467 |

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| A 000 | Initial Comments<br><br>An unannounced Complaint (#2022009134 and #2022009152) and Generator Monitoring survey was conducted on and at Harborchase of Wellington Crossing. The facility had deficiencies related to the Complaints at the time of the survey. | A 000 | | |
| A 025 | 429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision<br><br>429.26<br>(7) The facility shall 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 must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition.<br><br>59A-36.007 Resident Care Standards.<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: | 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<br><br>(a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C.<br>(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.<br>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.<br>(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.<br>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to provide adequate supervision appropriate to each resident's care needs, diagnosis and [redacted] status, for 2 out of 2 sampled memory care residents' files reviewed. As evidence of Resident #1 and Resident #2, who eloped together undetected from the facility's secured Memory Care Unit (MCU).<br><br>The findings included:<br><br>Review of the facility's investigative report documented on [redacted] at approximately 4:45 | A 025 | | |

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| A 025 | Continued From page 2<br><br>PM, Resident #1 and Resident #2 were seen in the community having dinner in the MCU dining room by Resident Care Manager (Staff C), Care Partner Staff K and Care Partner Staff L. At approximately 5:05 PM, a driver stopped at the communities' front desk to inform them they think two residents are trying to cross Lake Worth Road. At that time Care Partner Staff J went to look and saw the two residents, identified as Resident #1 and Resident #2. Care Partner Staff J then notified the nurse, got in a car and went and got the residents at the gas station. The residents were returned to the community safely by 5:15 PM.<br><br>Review of the facility policy titled Resident Checks dated with a revision date of , revealed the following protocol regarding elopements: Each resident will be observed and accounted for throughout the day by the care managers. In the , of the policy titled Memory Care Check Observations documented the following:<br>If it is determined during a Memory Care resident check that a resident is unaccounted for within the secured area or has eloped, the following is promptly initiated by the Care Associate and/or Director of Memory Care:<br>*All residents in the Memory Care are promptly accounted for.<br>*Assisted Living Standard R 1.07 Missing Resident protocols are promptly initiated by the Care Associates and/or Director of Memory Care.<br>*Determine elopement route and secure the exit door, courtyard gate, window and/or screen.<br>*Check and determine the security system is operating correctly by using the Assisted Living Operation Standard. 4.05.<br>*While assessing the security system or waiting for repairs, the Care Manager will | A 025 | | |

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| A 025 | Continued From page 3<br><br>promptly initiate necessary action steps to ensure the resident are safe and secure.<br><br>The facility did not immediately implement this procedure as they were not aware of the elopement until they were informed by an individual who observed Residents #1 and Resident #2 at a gas station down the street from the facility.<br><br>On . . . . . at 9:11 AM, this surveyor traveled the route Resident #1 and Resident #2 traveled from the facility to the gas station which is currently unopened and under construction and is located on Lake Worth Road, and is visible from the facility. The distance from the facility to the location of the gas station measured on this surveyor's odometer was 0.3 miles and is located just north of the facility on the south side of Lake Worth Road, a major 6-lane roadway that runs east and west.<br><br>On . . . . . between 4:46 PM and 5:10 PM, the time of day the residents were said to have eloped, a demonstration was conducted of the possible route by Resident #1 and Resident #2. To get to the gas station location Resident #1 and Resident # were said to have been found, would require they exit the facility and walk east along Lake Worth Road for approximately 0.3 miles, cross 6-lanes of roadway (3 east and 3 west), and into the covered gas station. Observation of the traffic on this day revealed it to be moderate, with a steady flow of cars heading in each direction. The speed limit observed was posted at 50 miles per hour.<br><br>Review of the temperature for Lake Worth, FL on . . . . . , the day of the elopement, from the website www.accuweather.com documented the | A 025 | | |

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| A 025 | Continued From page 4<br><br>temperature at 86 degrees. A review of The Weather Channel website https://weather.com recorded the temperature on [redacted] at 87 degrees at 5:48 PM.<br><br>In an interview conducted with Resident #1 and Resident #2 residing in the MCU on [redacted] at 11:38 AM, an inquiry was made as to the last time they walked together outside of the facility. The residents were able to communicate but could not recall or speak to the elopement. Specifically, there was no direct response to the question as Resident #1 began sharing he was an athlete in rowing and played golf. At 11:43 AM Resident #2 stated she was doing fine but was also unable to remember the elopement on [redacted].<br><br>Review of the record for Resident #1 revealed he was admitted to the MCU on [redacted]. Further review of the record revealed a Health Assessment (AHCA form 1823 form) dated [redacted] documenting his diagnoses to include [redacted] and [redacted]. It also documented he is slightly unsteady with ambulation, is a [redacted] risk and has mild [redacted].<br><br>Review of the record for Resident #2 revealed she was admitted to the MCU on [redacted]. Further review of the record revealed a Health Assessment (AHCA form 1823) dated [redacted] documenting her diagnoses to includes [redacted] and [redacted] Atrophy. It also documented she has [redacted] mobility, is hearing and vision [redacted] is a [redacted] risk and is alert with [redacted].<br><br>In an interview conducted with the Administrator on [redacted] at 12:06 PM, she stated she nor staff know how Resident #1 and Resident #2 | A 025 | | |

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| A 025 | Continued From page 5<br><br>exited the community. She further stated they were last seen at dinner time around 4:45 PM on . . . . . in the Memory Care Unit's dining room. She stated that at approximately 5:05 PM, a driver stopped at the community's front desk to inform them that they think two residents are trying to cross Lake Worth Road. At that time Staff J (Care Partner ) went to look and saw the two residents. Staff J (Care Partner) then notified the nurse, got in a car and went to get the residents. She stated Resident #1 and Resident #2 were returned to the community safely by 5:15 PM.<br><br>In an interview conducted with Staff J (Care Partner ) on at 4:34 PM, she stated she did not see anyone go through the front door. She stated she is the only one able to go in and out of the MCU with the key fob. She further stated that on the day of the elopement Resident #1 was trying to get out with the musician who had provided entertainment, and the musician told the resident he had to stay. She further stated in the interview that she was at the desk around the time of the elopement and never left the desk. She stated a lady came into the facility and said there are some residents down the street at the gas station. She stated she alerted other staff, and she and a family member went to the location the residents were alleged to be. She stated she arrived at the location and observed Residents #1 and Resident #2. She stated when she spoke to Resident #1 at the scene, he told her he wanted to go to the university. She then stated that Resident #1 and Resident #2 got in the car and returned to the facility with her. She further stated she asked Resident #1 how he got out of the facility, and he said through the gate.<br><br>On the courtyard area was observed | A 025 | | |

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| A 025 | Continued From page 6<br><br>to have a 6- . . -high white plastic panel fence securing the entire area. Observation was made of a gate on the south end and north end of the courtyard. During this observation, the length of the courtyard was . . . . . and an attempt to exit through both doors which were controlled by a keypad/fob, revealed they were both locked. Additionally, on . . . . at 11:28 AM, an observation was conducted of the Memory Care's entry/exit door located near the front south entrance of the facility which leads into the main lobby area. There is a break-bar on the door which was pushed and held for more than 30 seconds but did not open. Observation was made of a camera located at the top-left section of the ceiling by the door. The feed is sent to a camera that is located at the front desk and is monitored by the front desk staff.<br><br>On . . . . . at 11:34 AM, the Memory Care's entry/exit door located near the . . . north end of the facility, revealed it is a similar double door to the double doors at the front of the facility. No camera was observed at the door, nor was there an alarm on the door. The break-away bar was pushed for more than 30 seconds and the door did not open.<br><br>In an interview conducted with Staff I (Concierge) on . . . . . at 11:41 AM, she stated they can see who is at the inside of the door. Observation conducted during the interview revealed the monitor had no visual. Staff I stated the signal was out and had been going in and out for a while.<br><br>Review of the Memory Care Unit sign-in/sign-out logs were conducted for the date of the elopement, . . . . . , revealing there were 7 visitors to the MCU. Further review revealed 4 | A 025 | | |

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| A 025 | Continued From page 7<br><br>visitors did not sign out, so it was unknown what time they departed. There were 2 guests visiting a resident that signed out at 4:15 PM, around the time of the elopement. It is unknown if Resident #1 and Resident #2 tailgated them as the camera at the door of the MCU did not record. Further, the facility could not determine how Resident #1 and Resident #2 eloped from the secured MCU undetected, confirmed by the Administrator.<br><br>Class III | A 025 | | |