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
	AL11910258	A. BUILDING: _____ B. WING _____	C 01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NEW PORT RICHEY	6400 TROUBLE CREEK ROAD NEW PORT RICHEY, FL 34653

(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 A biennial re-licensure survey, a complaint investigation (complaint numbers: 2022016342 and 2022016469), and a generator monitoring were conducted at Brookdale of New Port Richey on . Deficiencies were identified at the time of survey.	A 000		
A 010 SS=D	429.26(.) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident,	A 010		

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A 010	Continued From page 1 additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the	A 010		

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A 010	Continued From page 2 applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's	A 010		

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A 010	Continued From page 3 record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities	A 010		

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A 010	Continued From page 4 holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain resident consent form that the resident agreed to hospice services and failed to obtain an interdisciplinary care plan, which specified the services provided by hospice and those provided by the facility and agreed upon by hospice, the facility, and the resident (or resident's responsible Party) for one Residents (#11) of two sampled residents admitted to hospice services. Findings Included: A record review for Resident #11, conducted on . . . . . , revealed that Resident #11 was admitted to the facility on and into hospice services on an unknown date. Resident #11's record did not include a consent form that the resident agreed to hospice services. Resident #11's health assessment form dated did not note that the resident required hospice nursing services on page one. There was no order from a health care provider that Resident # , be admitted to hospice services located in the record. Resident #11's record did not include an interdisciplinary care plan, which specified the services provided by hospice and those provided by the facility and agreed upon by hospice, the facility, and the resident (or resident's responsible party). During an interview with the Administrator and Health and Wellness Director, conducted on at 04:15pm, the Administrator and Health and Wellness Director agreed that Resident #11's record did not include a consent	A 010		

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A 010	Continued From page 5 form for hospice services, an order from a health care provider for admission to hospice services or hospice interdisciplinary care plan. Class III	A 010		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (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. 59A-36.007 Resident Care Standards. 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	A 025		

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A 025	Continued From page 6 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 observation, record review, and interview, the facility failed to meet the needs for twenty-nine residents who were at risk for elopements and resided in the facility's memory care and . . . . . unit. Findings Included: A review of a facility incident reported to The Agency for Resident #9, conducted on . . . . . , revealed that Resident #9 eloped from the facility on at approximately 11:40pm by stacking patio furniture next to the twelve- fence that surrounded the facility's	A 025		

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A 025	Continued From page 7 memory care courtyard. Resident #9 as found by law enforcement at a nearby residence (approximately 0.1 mile away) and was returned to the facility. The facility's corrective actions noted on the facility report noted that the facility's Maintenance Director added alarms to the memory care courtyard/patio doors. During an interview with Staff E (Memory Care licensed practical Nurse), conducted on . . . . . at 10:56am, Staff E stated that she was not aware of any elopements from the memory care unit. Staff E stated that the memory care courtyard fence gate was locked and alarmed. During an interview with the Assistant Administrator, conducted on at 01:13pm, the Assistant Administrator stated that she was not sure how Resident #9 got out of the locked and secured memory care unit. The Assistant Administrator stated that the memory care courtyard doors were not locked but that the fence was secured (referring to the gate). The Assistant Administrator was not sure how often the staff checked the memory care courtyard. During an interview with Staff D, conducted on . . . . . at 02:26pm, Staff D stated that he assisted with the search when Resident #9 eloped from the facility's locked and secured memory care unit. Staff D was not sure how Resident #9 eloped. Staff D stated that staff believe that Resident #9 climbed over the memory care courtyard fence and that he believed that the resident crawled out of his broken window. Staff D stated that the memory care courtyard doors were supposed to be locked at certain times. Staff D stated residents were usually asleep on his shift and sweeps of the	A 025		

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A 025	Continued From page 8 courtyard were not performed. During an interview with Staff C, conducted on at 02:40pm, Staff C stated that Resident #9 was ˬ at shift change on (the night the resident eloped). Staff C was not sure how Resident #9 got out of the locked and secured memory care unit. An observation of the facility memory care unit, conducted on from 03:00pm through 03:30pm, residents were roaming throughout the facility. Most of the residents were in the center of the building in the dining room. There were four staff observed in this area. At the end of the hallway to the left of the dining room was a sitting/activity/television area. This area had two doors on each side of the room that led to the fenced memory care courtyard. Resident #23 was ˬ out one door and in through the other door repeatedly. There were no alarms that sounded to either door when the Surveyor and Resident #23 walked in and out of the unit. There was no staff observed in or around this area for approximately twenty minutes. The courtyard had a six- fence surrounding the area with a locked gate. During an interview with Staff M, conducted on at 03:20pm, Staff M stated that the memory care patio/courtyard doors were never locked or alarmed. During an interview with Staff P, conducted on at 03:20pm, Staff P was unable to verbalize how staff knew when ˬ residents left the memory care unit to go out into the courtyard. At 03:25pm, Staff P stated that the memory care patio/courtyard doors were never locked or alarmed.	A 025		

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A 025	Continued From page 9 During an interview with Staff A, conducted on [redacted] at 03:23pm, Staff A stated that she noticed that Resident #9 was not in his room when the staff did her oncoming duty rounds. Staff A stated that Resident #9 liked to [redacted]. Staff stated that the memory care courtyard patio doors were not alarmed and that the facility added alarms to the doors that led to the memory care courtyard after Resident #9 eloped from the facility. Staff A stated that the memory care courtyard was checked every two hours. During an interview with Staff N, conducted on [redacted] at 03:30pm, Staff N stated that the memory care patio/courtyard doors were never locked or alarmed. During an interview with Staff E, conducted on [redacted] at 03:29pm, Staff E stated that the memory care patio/courtyard doors were never locked or alarmed. A record review for Resident #9, conducted on [redacted], revealed that Resident #9 was admitted to the facility on [redacted] and eloped from the facility on [redacted]. Resident #9's health assessment form dated [redacted] noted that Resident #9 was not an elopement risk. Resident #9's personal service plan dated [redacted] noted that the resident was at high risk for elopements due to functionality stable with strong rapid gait and frequent attempts to leave community close monitoring and attempts needed to keep the resident involved and distracted to reduce [redacted]. It was documented that Resident #9 had multiple attempts to exit the building without needed supervision. A review of the facility's "Elopement Risk Policy	A 025		

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A 025	Continued From page 10 FL-4" dated . . . . . and revised . . . . , , , , and , conducted on . . . . . , revealed that residents at risk for elopements were to have their risk for elopement noted on their health assessment form and that all residents that resided in the facility's memory care and . . . . . unit was considered at risk for elopement. A review of the facility's "Courtyard - Secured Patio Access Policy - OR-22" dated . . . . . , conducted on , revealed that the facility's memory care courtyard patio doors were supposed to be locked and alarmed from dusk to dawn and during inclement weather and that the facility should provide for periodic monitoring of residents in the courtyards and secured patios. A review of staff that had not participated in the facility's elopement response drills, conducted on . . . . . , revealed that there were thirty-three Resident . and Medication Technicians that had not participated in the facility's elopement response drills in which Staff B, C, and D were involved in Resident #9's elopement. During an interview with the Administrator and the Health and Wellness Director, conducted on . . . . . at 04:00pm, the Administrator and the Health and Wellness Director agreed that many current staff had not participated in elopement response drills. The Administrator and the Health and Wellness agreed that the facility was not following the facility policy and procedures regarding keeping the memory care patio/courtyard doors locked and alarmed from dusk to dawn. The Administrator and the Health and Wellness Director agreed that Resident #9 did not obtain an updated health assessment form that noted that the resident was at risk for	A 025		

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A 025	Continued From page 11 elopements after the resident eloped from the facility. Class III	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) 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), 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.	A 032		

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A 032	Continued From page 12 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 Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to conduct elopement drills that included all direct care staff participation for nine employees (Staff B, C, D, E, G, H, I, J, and K) of thirty-three sampled employees that had not participated in elopement response drills. Furthermore, the facility failed to have an elopement response policy and procedures that	A 032		

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A 032	Continued From page 13 at a minimum an immediate search of the facility and premises, the identification of staff responsible for implementing each part of the elopement response policy and procedures and specific duties and responsibilities, and the identification of the staff responsible for contacting law enforcement, the resident's responsible party, the case manager, and the State Agencies. Findings Included: A review of the facility "Elopement Risk Policy FL-4" dated and revised on , , , , and , conducted on , revealed that The policy and procedures did not note an immediate search of the facility and premises. The policy and procedures did not note the identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities. The policy and procedures did not note the identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager. The policy and procedures did not note the continued care of all residents within the facility in the event of an elopement. A review of the facility's elopement drills, conducted on , revealed that there were thirty-three employees that had not participated in elopement drills which included but not limited to eighteen Resident and eleven Medication Technicians. Of these thirty-three employees, a personnel record review of nine employees which included Staff B, C, D, E, G, H, I, J, and K revealed none of the Staff reviewed participated in an elopement response drill.	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910258	A. BUILDING: _____ B. WING _____	C 01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NEW PORT RICHEY	6400 TROUBLE CREEK ROAD NEW PORT RICHEY, FL 34653

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A 032	Continued From page 14 An employee record review for Staff B, C, D, E, G, H, I, J, and K, conducted on [redacted], revealed that Staff B (Resident Aid) was hired on [redacted]. Staff C (Resident Aid) was hired on [redacted]. Staff D (Resident Aid) was hired on [redacted]. Staff E (licensed practical Nurse) was hired on [redacted]. Staff G (Resident Aid) was hired on [redacted]. Staff H (Medication Technician) was hired on [redacted]. Staff I (Medication Technician) was hired on [redacted]. Staff J (Resident Aid) was hired on [redacted]. Staff K (Medication Technician) was hired on [redacted]. During an interview with the Administrator and the Health and Wellness Director, conducted on [redacted] at 04:00pm, the Administrator and the Health and Wellness Director agreed that there were many staff that had not participated in an elopement response drill. The Administrator and the Health and Wellness Director was unable to provide an elopement response policy and procedures that included all required elements. Class III	A 032		