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AHCA
AGENCY CLERK
2021 SEP 13 A 11: 27

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v. **AHCA NO. 2021007954**

PRUITTHEALTH-SANTA ROSA, LLC d/b/a PRUITTHEALTH-SANTA ROSA,

Respondent.
_______________________________________/

FINAL ORDER

Having reviewed the Administrative Complaint, and all other matters of record, the Agency for Health Care Administration finds and concludes as follows:

1. The Agency issued the attached Administrative Complaint and Election of Rights form to the Respondent. (Ex. 1) The Election of Rights form advised of the right to an administrative hearing. The Respondent received the Administrative Complaint and Election of Rights form and selected Option 1 on the Election of Rights form. (Ex. 2) The Respondent thus waived the right to a hearing to contest the allegations and sanction sought in the Administrative Complaint.

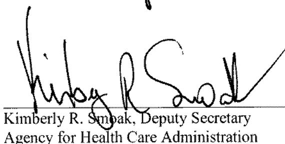
Based upon the foregoing, it is **ORDERED:**

1. The findings of fact and conclusions of law set forth in the Administrative Complaint are adopted and incorporated by reference into this Final Order.

2. The Respondent shall pay the Agency $26,000.00. In addition, the Respondent is assigned conditional licensure status effective April 23, 2021, and ending May 21, 2021. If full payment has been made, the cancelled check acts as receipt of payment and no further payment is required. If full payment has not been made, payment is due within 30 days of the Final Order. Overdue amounts are subject to statutory interest and may be referred to collections. A check made payable to the "Agency for Health Care Administration" and containing the AHCA ten-digit case number should be sent to:

Central Intake Unit
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 61
Tallahassee, Florida 32308

ORDERED at Tallahassee, Florida, on this 13th day of September, 2021.



Kimberly R. Smoak, Deputy Secretary
Agency for Health Care Administration

NOTICE OF RIGHT TO JUDICIAL REVIEW

A party who is adversely affected by this Final Order is entitled to judicial review, which shall be instituted by filing one copy of a notice of appeal with the Agency Clerk of AHCA, and a second copy, along with filing fee as prescribed by law, with the District Court of Appeal in the appellate district where the Agency maintains its headquarters or where a party resides. Review of proceedings shall be conducted in accordance with the Florida appellate rules. The Notice of Appeal must be filed within 30 days of rendition of the order to be reviewed.

CERTIFICATE OF SERVICE

I CERTIFY that a true and correct copy of this Final Order was served on the below-named persons by the method designated on this 13th day of September, 2021.

Richard J. Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308-5403
Telephone: (850) 412-3630

Facilities Intake Unit Agency for Health Care Administration \(Electronic Mail)	Central Intake Unit Agency for Health Care Administration (Electronic Mail)
Maurice Boetger, Senior Attorney Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Charles W. Jackson, Jr., Administrator Pruitthealth-Santa Rosa, LLC d/b/a Pruitthealth-Santa Rosa 5530 Northrop Road Milton, Florida 32570 wwjackson@pruitthealth.com (Electronic Mail)

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs. AHCA No. 2021007954

PRUITTHEALTH-SANTA ROSA, LLC
d/b/a PRUITTHEALTH-SANTA ROSA,

Respondent.
_______________________________/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Agency for Health Care Administration ("the Agency"), by and through the undersigned counsel, and files this Administrative Complaint against the Respondent, Pruitthealth-Santa Rosa, LLC d/b/a Pruitthealth-Santa Rosa ("the Respondent"), and alleges:

NATURE OF THE ACTION

This is an action against a nursing home to: impose an administrative fine of $20,000.00; assign conditional licensure status effective April 23, 2021 and ending May 21, 2021; and assign six month survey cycle and $6,000.00 fine (for a total fine of $26,000.00), based on two isolated class I deficiencies.

PARTIES

1. The Agency is the regulatory authority responsible for licensure of nursing homes and enforcement of applicable state statutes and rules governing skilled nursing facilities pursuant to Chapters 400, Part II, and 408, Part II, Florida Statutes. (2020), and Chapter 59A-4, Florida Administrative Code.

2. The Respondent was issued a license by the Agency to operate a nursing home ("the Facility") and was at all times material required to comply with the applicable statutes and rules governing nursing homes.

COUNT I
Right To Adequate and Appropriate Health Care

3. Under Florida law,

> All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:
> (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

§ 400.022(1)(l), Fla. Stat. (2020).

4. On or about April 19, 2021, to April 23, 2021, the Agency conducted a survey of the Facility.

5. Based on observation, interview, and record review, the Facility failed to provide adequate supervision for residents with wandering and exit-seeking behaviors, by failing to ensure that two vulnerable residents at risk for elopement (Resident #40 and #48) were not able to exit the building unsupervised on 3/7/21 (Resident #40) and 3/9/21 (Resident #48). The Facility's failure to provide adequate supervision may prevent the Facility from correcting and improving its systems to ensure resident safety and prevent serious harm to each of the 28 residents in the Facility who were identified as at risk for elopement. The Facility's failure to prevent an elopement and eliminate potential hazards placed two residents (Resident #40 and #48) at an increased likelihood of serious injury and death. An eloped resident is at risk for being injured or killed, for example, by cars on the highly traveled Berryhill Road (which is

approximately .4 miles south of the Facility), by falling and injuring themselves, or by drowning in a holding pond (there are holding ponds located south of the Facility).

6. On 4/22/21, the Facility's Safety Events-Wandering Event Report (dated 3/9/21) was reviewed. According to that report, Resident #48 was found outside the Facility sitting on a bag of sand under a tree. According to that report, the attending was not faxed, the physician was not notified, the resident's representative was not notified, and the care plan was not reviewed. According to that report, the Facility had evaluated Resident #48 and was seeking placement at a secured unit. According to that report, Resident #48's picture was posted at the nursing units and other appropriate places. According to that report, an immediate plan of care for elopement had been initiated. According to that report, a resident monitoring device was not in place for Resident #48. At that time, all other sections of that report, including: physical observation (when and where the resident was found, if the resident sustained any injury during the elopement period, if the resident exhibited any behaviors prior to the elopement, etc....), mental status, possible contributing factors, interventions- immediate measures taken, notification guidelines, and orders, were blank.

7. A Social Services note, dated 3/9/21 at 2:45 PM, regarding Resident #48 was reviewed. According to that note, Resident #48 continued wandering, was ambulating independently throughout the Facility, and seemed more restless and easily agitated over the past two days. According to that note, Resident #48 always enjoyed being outside. According to that note, with the weather being sunny and warm for the past two days and an exercise class being held in the courtyard, Resident #48 had been looking to go outside. According to that note, Resident #48 went outside to the dining room patio area and was observed by staff and escorted to a hallway area. According to that note, Resident #48 was to be placed on direct behavior

monitoring and a Licensed Clinical Social Worker was going to continue to seek out a secure facility/unit. According to that note, Resident #48's long-term care representative was also aware of Resident #48's needs. According to a Social Services note, dated 3/9/21 at 3:01 PM, a Licensed Clinical Social Worker called and left a message for Resident #48's daughter regarding Resident #48's status and the ongoing seeking for a secure unit/facility.

8. A Nurse progress note, dated 3/9/21 at 7:21 PM, regarding Resident #48 was reviewed. According to that note, Resident #48 was alert with confusion. According to that note, the following behaviors were noted as baseline: yelling, cussing at staff and self, talking to self, wandering in hallways, trying to go home, and exhibiting exit-seeking behavior. According to that note, Resident #48 was redirected by staff, encouraged to participate in activities and reading to prevent those behaviors. According to that note, close monitoring continues due to Resident #48's exit-seeking behavior.

9. An annual Minimum Data Set assessment, dated 2/13/21, for Resident #48 was reviewed. According to that assessment, Resident #48 was rarely or never understood. According to that assessment, Resident #48 had severe mental impairment and never or rarely made decisions. According to that assessment, Resident #48 displayed inattention and disorganized thinking. According to that assessment, Resident #48 had behaviors including wandering daily and that wandering placed Resident #48 at significant risk of getting to a potentially dangerous place. According to that assessment, Resident #48's balance during transition and walking was not steady, but able to stabilize without human assistance for all.

10. An Elopement Risk Observation form (the Facility's internal elopement risk assessment tool), dated 2/24/21, for Resident #48 was reviewed. According to that form, Resident #48 received a score of 17. According to that form, the scoring scale is 0-4- low risk, 5-

10- moderate risk, and 11 or greater- high risk. A score of 17 indicates that Resident #48 was at high risk for elopement. That form lists interventions including, 3-day monitoring, weekly Behavioral Management, and Wanderguard Program.

11. Nurse progress notes were reviewed regarding Resident #48. Nurse progress notes were reviewed which indicate that Resident #48 had a history of exit-seeking behaviors. According to a note, dated 2/14/21 at 7:37 PM, Resident #48 wandered around the Facility all day, trying to exit via locked doors. According to that note, Resident #48 was redirected by staff, given snacks, and encouraged to drink fluids. According to that note, Resident #48 was given as needed anxiety medication and no effectiveness was noted. According to that note, Resident #48 continued to wander, cuss at self and staff, and exhibit anxious behavior. It appears from the nurse progress notes that Resident #48's exit-seeking behavior continued after the elopement event on 3/9/21. According to a note, dated 3/26/21 at 3:50 PM, Resident #48 continued to exit-seek and became very anxious with confusion. According to that note, Resident #48's daughter said that she sent four placement options to the Social Worker at the Facility today for a locked unit for Resident #48. According to that note, Resident #48's daughter stated that it was difficult to find one that will take a particular insurance and that is secure.

12. Nurse Practitioner progress notes regarding Resident #48 were also reviewed. Nurse Practitioner progress notes were reviewed which indicate that Resident #48 had exit-seeking behaviors prior to the elopement incident. According to a note, dated 2/18/21 at 1:43 PM, Resident #48 had no acute distress and was seen today per staff's request for increased behaviors, exit-seeking, and agitation. According to a note, dated 3/26/21 at 11:29 AM, Resident #48 had no acute distress and was seen today per staff request to assess ongoing behaviors, exit-seeking, and agitation.

13. Social Services notes regarding Resident #48 were reviewed. Social Service notes were reviewed which indicate that attempts were made to locate a facility with a secured unit prior to Resident #48's elopement. According to a Social Services note, dated 2/23/21 at 8:53 PM, a Licensed Clinical Social Worker had sent referral packets to several facilities that have a secured area/unit due to Resident #48 continuing to exit-seek. After Resident #48's elopement on 3/9/21, the Licensed Clinical Social Worker documented ongoing attempts to find placement at a secured unit in notes on 3/22/21, 3/23/21, and 3/26/21.

14. Resident #48's Plan of Care, dated 3/9/21, was reviewed. According to that plan, Resident #48 had behavioral symptoms for being socially inappropriate/disruptive behavioral symptoms as seen by yelling, cursing, and combativeness with staff. That plan noted a start date of 4/28/20. According to that plan, discharge planning was initiated on 2/10/20. However, that plan does not identify the need for a secured or locked unit. Wandering or exit-seeking behaviors was not initiated on that plan until 3/9/21, after Resident #48's elopement. On that plan, the category was identified as behavioral symptoms and at risk for elopement related to wandering behavior. According to that plan, Resident #48 will not have any severe injuries related to elopement. That plan indicates to ensure Resident #48's needs are met during wandering episodes such as dry, hunger, and thirst. However, that plan did not list interventions that would prevent Resident #48 from eloping from the Facility.

15. Resident #48's Medication Administration Record (MAR) was reviewed. On the behavioral monitoring entries, it was noted that code "8" meant that wandering was displayed during the shift. For the month of March 2021, it was indicated that Resident #48 was wandering on 22 of 31 days during the day shift (3/4, 3/5, 3/6, 3/7, 3/8, 3/9, 3/11, 3/13, 3/14, 3/15, 3/16, 3/17, 3/18, 3/19, 3/20, 3/21, 3/22, 3/24, 3/25, 3/26, 3/27, and 3/31) and 15 of 31 days during the

night shift (3/2, 3/3, 3/4, 3/7, 3/11, 3/15, 3/18, 3/19, 3/21, 3/22, 3/25, 3/27, 3/28, 3/30, and 3/31). For the month of April 2021, it was indicated that Resident #48 was wandering on 16 of 22 days during the day shift (4/1, 4/2, 4/3, 4/5, 4/6, 4/9, 4/10, 4/11, 4/12, 4/13, 4/15, 4/17, 4/18, 4/19, 4/20, and 4/22) and seven of 22 days during the evening shift (4/1, 4/2, 4/5, 4/12, 4/14, 4/19, and 4/22).

16. On 4/21/21 at approximately 8:04 AM, an interview was conducted with Licensed Practical Nurse L. Licensed Practical Nurse L stated that Resident #48 liked to wander around the Facility, both inside and outside as well as in the courtyard. Licensed Practical Nurse L stated that Resident #48 thought that Resident #48 could go home, so Resident #48 would try to go outside. Licensed Practical Nurse L stated that Resident #48 had wandered outside, behind the building and was brought back in. Licensed Practical Nurse L stated that she was unsure of how long Resident #48 was out of the building. Licensed Practical Nurse L stated that all the doors have alarms and will alarm throughout the building when they are opened. Licensed Practical Nurse L stated that, at the time of the elopement, the door alarm was functioning. Licensed Practical Nurse L stated that she notified all required staff, the Administrator, the Nurse Practitioner, the family, and Social Services. Licensed Practical Nurse L verified that Resident #48 had not eloped since the incident on 3/9/21.

17. On 4/21/21 at approximately 10:37 AM, an interview was conducted with the Facility's Risk Manager. The Risk Manager stated that she remembered Resident #48's elopement, that an announcement was made, and all staff went room by room checking for the resident. The Risk Manager stated that, she, the Facility's Clinical Care Coordinator, and the Facility's Director of Therapy checked the outside grounds and found Resident #48 sitting on a bag of sand leaning up against a fence. The Risk Manager stated that she felt that Resident #48

had gone through the dining room door. The Risk Manager stated that the Facility had fire safety doors, which will open if you keep pushing on them. The Risk Manager was asked how the Facility was made aware that Resident #48 was out of the building. The Risk Manager replied that they got a call from a neighbor that was behind the fence-line who wanted to make sure that the resident was okay and should be out there. The Risk Manager stated that there was an alarm on the door. The Risk Manager stated that the alarm sounds on the door itself, but it is hooked to the whole system so you can hear it throughout the building. The Risk Manager stated that the alarm had been silenced because when a staff member checked to see why the door was going off, Resident #48 was not in sight. The Risk Manager stated that Resident #48 got away from the door quicker than someone could get to the area to see Resident #48, so they were under the understanding that everything was clear. The Risk Manager stated that a person from the neighborhood let them know that Resident #48 was out there. The Risk Manager was asked for the incident investigation with the root cause analysis. The Risk Manager replied that the investigation should be in the computer in progress notes. The Risk Manager stated that she would check in her filing system. During this survey, documentation of the investigation was not provided.

18. On 4/21/21 at approximately 11:18 AM, an interview was conducted with the Licensed Clinical Social Worker. The Licensed Clinical Social Worker stated that Resident #48 had a pattern of wandering the Facility. The Licensed Clinical Social Worker stated that, on the day that Resident #48 eloped, the alarm sounded, and Resident #48 walked out the door. The Licensed Clinical Social Worker stated that Resident #48 got out of the door in the back patio area and that Dietary and two gentlemen were working back there on the generator. The Licensed Clinical Social Worker stated that they said that Resident #48 was sitting on pallets, so

staff went around there, and got Resident #48. The Licensed Clinical Social Worker stated that, when Resident #48 got back in, Resident #48 was put on direct supervision with a Certified Nursing Assistant. The Licensed Clinical Social Worker stated that she has spoken with Resident #48's daughter and they are desperately looking for a secure facility.

19. On 4/21/21 at approximately 2 PM, the Facility's Administrator entered the conference room and stated that there was video footage of the elopement incident. The Administrator was asked to produce the video recording for the Agency's Surveyor to review. The Administrator returned a few minutes later and stated that she did not have footage of Resident #48 exiting the Facility, she only had footage of Dietary staff going to the door and turning off the alarm. The Administrator stated that it was a new system and one can only pull so much from the past. The Administrator was asked how she had a video recording of the staff member checking the door but was unable to get video of Resident #48 leaving. The Administrator replied that it is mandated by corporate and that she did not have access to it. The Administrator stated that Corporate Maintenance Director was the one that was able to send it to her.

20. On 4/21/21 at approximately 2:35 PM, the Administrator provided a printed email from Corporate Maintenance Director which indicated that the video camera recording can only go back seven days.

21. On 4/21/21 at approximately 2:43 PM, an interview was conducted with the Corporate Maintenance Director. The Corporate Maintenance Director stated that he does not have anything, and he does not save anything. The Corporate Maintenance Director stated that it was a brand-new system. The Corporate Maintenance Director stated that it automatically deletes after seven days. The Corporate Maintenance Director stated that whatever the Administrator has

is what they have. The Corporate Maintenance Director stated that he thinks that he texted the video to the Administrator. The Corporate Maintenance Director stated that it was with his personal phone, that it has a limited amount of data, and that he does not keep it on his phone.

22. On 4/21/21 at approximately 2:49 PM, the video recording was reviewed with the Facility's Administrator and the Facility's Business Office Manager. In the video, it appears that a man walks from the kitchen area across the dining room to the door that exits to the area outside of the dining room (where Resident #48 exited the building on 3/9/21). In the video, it appears that the man does something near the door for a few moments, ducks, looks for a moment, and then walks away from the door and out of the frame. The video does not show Resident #48 exiting the dining room. The video does not show if a staff member had seen Resident #48 from the doorway.

23. On 4/22/21 at approximately 1:32 PM, the area that Resident #48 eloped from was observed. A door with a pin number lock was observed leading out to an open area by a gazebo. At that time, the open area was not secured with a gate or lock and appeared to lead directly to an open area parking lot.

24. On 4/22/21 at approximately 1:33 PM, an interview was conducted with the Facility's Director of Nursing, the Facility's Administrator, and the Licensed Clinical Social Worker. The Administrator stated that, on the day of the event, they called a code pink (an emergency announcement that uses a color system to identify facility emergencies, pink is used to identify a missing resident). The Administrator stated that she pulled her keys out of her purse, drove around the building, and, when she got around to the side, there were already a bunch of people outside. The Administrator stated that it was like a few seconds. The Administrator stated that there were generator people working out back and that it was the boys on the generator who

saw Resident #48 and who called out. The Administrator stated that they came and told the Business Office Manager. During this interview, they were asked how staff knew which residents are elopement risks. The Licensed Clinical Social Worker replied that they have elopement books at the receptionist's desk and the north and south nurses' stations. The Licensed Clinical Social Worker stated that the books contain pictures, face sheets (with demographic information like name, address, etc.…), care plans, and the assessment itself. During this interview, they were asked what constituted a reportable elopement. The Director of Nursing replied, when someone that is not themselves gets out of the Facility unannounced and their Brief Interview for Mental Status (BIMS) supports that they are not aware enough. During this interview, they were asked about hazards in the area. The Director of Nursing replied that there was a retention pond south of the Facility and that there is a black chain-link fence running along the entire property. The Director of Nursing stated that Berryhill Road is not far from the Facility and is a high traffic area. During this interview, they were asked about standard reporting requirements for elopements. The Licensed Clinical Social Worker replied that she would let the Administrator and the Risk Manager know. During this interview, they were asked what is the appropriate response to a door alarm sounding. The Director of Nursing replied that when an alarm goes off, nursing staff are to respond immediately. The Director of Nursing stated that when they go out the door, they should go through it and investigate the grounds. The Director of Nursing stated they should make sure no one went out. The Director of Nursing stated that they should search. The Director of Nursing stated that they should call her if there was an elopement. The Director of Nursing stated that they should be calling if there is any behavior out of the norm. The Director of Nursing stated that clear documentation would have made this a lot easier. During this interview, they were asked about standard reporting requirements for elopements.

The Licensed Clinical Social Worker replied that she would let the Administrator and Risk Manager know. The Licensed Clinical Social Worker stated that it would be immediate like everything else. The Administrator stated that the Risk Manager failed to document appropriately on the in-service form what it was that she was educating staff on. The Administrator stated that they need to talk to her about root cause analysis and the why, why, why. The Administrator stated that that is something that they can improve on. The Administrator was asked who was responsible for oversight of the Risk Manager, who would review her work to determine if it was completed correctly, and who was responsible for following up on her performance and to make a plan of correction, The Administrator indicated that it was the Administrator. The Administrator stated that the Risk Manager documented that it was an effective drill, that staff responded appropriately, and that the patient had no ill effects. The Administrator stated that, in her perception, the search went well knowing that Resident #48 went out for an evening stroll and likes to talk to people. The Administrator stated that, in reality, for her first drill she did a good job on the paper compliance and assessing the compliance. The Administrator stated that she said that this was an opportunity to do it as a drill. The Administrator stated that they all took their action steps and they all checked for safety and security. The Administrator stated that she would absolutely use it as a drill. The Administrator agreed that the situation was not a pre-planned drill. The Administrator agreed that nothing presented to the Surveyor at that time demonstrated a root cause analysis of how Resident #48 was able to elope from the building.

25. On 4/23/21 at approximately 10:10 AM, an interview was conducted with Staff F (a Registered Nurse and a Unit Manager). Staff F stated that they do elopement assessments on admission, quarterly, and annually, completed by the Unit Manager. Staff F stated that the

admitting nurse does admission elopement assessments. Staff F stated that they have a widget (pop-up alert) that comes up in their electronic documentation system, which reminds them that the elopement assessment is due. Staff F stated that, for example, April and May's assessments are in there now. Staff F stated that she will analyze the first assessment, or the previous one, and then see what changes occurred with the new assessment. Staff F stated that if a resident has gone from a moderate to a high risk for elopement, they update the care plan and notify the Risk Manager who adds them to the book. Staff F stated that she notifies the Minimum Data Set Nurse to update care plans or Staff F does it herself. Staff F stated that normally the Minimum Data Set Nurse does it. Staff F stated that she has been here a year. Staff F stated that the front entrance door has always had a code on it. Staff F stated that she believes that it has been the same code since she has been here. Staff F stated that there was one day that she could not get in as they had changed the code at least once. Staff F stated that if a door alarm is activated it is very loud and is easily heard at the opposite side of the building. Staff F stated that when the wall alarm monitor goes off it lights up and tells them what part of the Facility the alarm is located in. Staff F stated that the plaque above the monitor has a location list with numbers and location details. Staff F stated that there was discussion about Resident #48, who exited the Facility last month. Staff F stated that Resident #48 had exit-seeking behaviors. Staff F stated that the Director of Nursing had a discussion with her regarding monitoring residents and keeping an eye on those with exit-seeking behaviors.

26. On 4/23/21 at approximately 11:58 AM, an interview was conducted with Certified Nursing Assistant K. Certified Nursing Assistant K was asked if it would be safe if Resident #48 was out in the community without supervision. Certified Nursing Assistant K replied that it would not be safe for Resident #48 to be out in the community unattended.

Certified Nursing Assistant K stated that she knows that Resident #48 wanders. Certified Nursing Assistant K stated that she would worry that Resident #48 would find him or herself in an unsafe situation. Certified Nursing Assistant K stated that Resident #48 is steady on his or her feet, can walk and get around, but his or her decision making is not great. Certified Nursing Assistant K stated that Resident #48's cognitive (mental) function is very low. Certified Nursing Assistant K stated that she would really be worried if Resident #48 was out on his or her own. Certified Nursing Assistant K was asked about elopement training. Certified Nursing Assistant K replied that she was not aware of an elopement book. Certified Nursing Assistant K stated that she finds out about elopement risks through shift reports. Certified Nursing Assistant K was asked how elopement education is provided. Certified Nursing Assistant K replied that there was education provided on elopement, but also stated that she does not recall how often or when the last time was that it was done.

27. On 4/23/21 at approximately 11:03 AM, an interview was conducted with Dietary Aide S. Dietary Aide S confirmed that he was the staff member in the video shown to the Surveyor. Dietary Aide S stated that he was coming back from break when he heard the alarm to the door going off. Dietary Aide S stated that, when he walked over, he saw several staff members outside with Resident #48. Dietary Aide S stated that he then turned off the alarm and returned to his work area.

28. On 4/23/21 at approximately 11:07 AM, an interview was conducted with a Nurse Practitioner. The Nurse Practitioner stated that she just found out yesterday that Resident #48 went outside the Facility last month. The Nurse Practitioner stated that she was not sure of the exact date when that happened. The Nurse Practitioner stated that she had not done any research, but that the Director of Nursing told her yesterday that Resident #48 had gone out of the

building. The Nurse Practitioner stated that Resident #48 had exit-seeking behaviors and would start going towards the door. The Nurse Practitioner stated that it was news to her that Resident #48 actually got out the door. The Nurse Practitioner stated that she had no other details about that. The Nurse Practitioner stated that there are comments by staff in progress notes regarding Resident #48 wandering through the halls, being pleasantly confused, and not being identified as exit-seeking in December. The Nurse Practitioner stated that, on 2/18/21, staff documented that Resident #48 had agitation and exit-seeking behaviors. The Nurse Practitioner stated that she ordered laboratory tests and a urine analysis. The Nurse Practitioner stated that Resident #48 refused the urine analysis but had normal test results. The Nurse Practitioner stated that she saw Resident #48 again, on 3/26/21, for ongoing behaviors, agitation, and exit-seeking. The Nurse Practitioner stated that Resident #48 again refused a urine analysis but had normal test results. The Nurse Practitioner stated that she has changed some of Resident #48's medications and has not seen Resident #48 since then. The Nurse Practitioner stated that she was never notified of the fact that Resident #48 got out. The Nurse Practitioner stated that she was aware that staff were redirecting Resident #48, trying to give Resident #48 chores, activities, and busy work. The Nurse Practitioner stated that there is no one on one (direct staff supervision). The Nurse Practitioner stated that they try as best as they can, and she does not think that they are able to staff one on one for Resident #48. The Nurse Practitioner stated that she knows that the Social Worker has been working on Resident #48's placement before Resident #48 started exit-seeking behaviors. The Nurse Practitioner stated that, on 3/9/21, the Social Worker reached out to Resident #48's family emergency contact to notify them of the need for a secure facility. The Nurse Practitioner stated that, on 3/26/21, the Social Worker again reached out to find Resident #48 somewhere more secure. The Nurse Practitioner stated that she was not aware of any other

interventions that are in place for Resident #48's behaviors and safety.

29. On 4/23/21 at approximately 11:07 AM, an interview was conducted with the Electrical Contractor via telephone. The Electrical Contractor stated that, on 3/9/21, he was at the Facility doing work on the Facility's generator. The Electrical Contractor was asked if he recalled the situation. The Electrical Contractor replied that it might have been the day that someone tried to get away. The Electrical Contractor stated that he was out back with the generator when he noticed Resident #48 walking around with a piece of carrot cake. The Electrical Contractor stated that he asked Resident #48 if Resident #48 knew where he or she was going. The Electrical Contractor stated that Resident #48 replied do not worry about it. The Electrical Contractor stated that Resident #48 moved passed him while looking left and right. The Electrical Contractor stated that he decided to walk around the building to let staff know of Resident #48's whereabouts. The Electrical Contractor stated that, immediately after, approximately 12 people showed up to bring Resident #48 back into the building. The Electrical Contractor stated that he estimates that the entire incident lasted about five minutes.

30. On 4/23/21 at approximately 1:03 PM, an interview was conducted with the Facility's Maintenance Director. The Maintenance Director was asked how the alarms work on the magnetically locked doors (like the one in the dining room). The Maintenance Director replied that those doors only alarm from the door itself. The Maintenance Director indicated that there are no other alarms in the building that go off to let staff know and that there is no indication on a control panel anywhere.

31. On 4/23/21 at approximately 2:18 PM, an interview was conducted with the Facility's Rehabilitation Director. The Rehabilitation Director stated that a Code Pink means a missing patient or resident. The Rehabilitation Director stated that if a Code Pink alarm goes out,

she goes outside, alerts any of her staff nearby, looks in hallway, checks/asks any staff what is going on, checks outside through a Fire Door, observes outside, and checks for any resident or someone for imminent danger. The Rehabilitation Director stated that she assisted Resident #48 back into the building approximately 6-8 months ago. The Rehabilitation Director stated that she was sitting in her office, she heard the fire door alarm going off in her gym, she got up, and she looked out the Main Therapy gym window. The Rehabilitation Director stated that she saw Resident #48 outside in the Gazebo area which has uneven ground and that scared the Rehabilitation Director the most. The Rehabilitation Director stated that there was no staff in sight, and it was around late morning before lunch. The Rehabilitation Director stated that she accessed the code for the fire door and escorted Resident #48 back into the Facility. The Rehabilitation Director stated that she asked Resident #48 how Resident #48 got out and Resident #48 said that he or she read the instructions on the door. The Rehabilitation Director stated that she called Resident #48's nurse (but indicated not remembering the nurse's name) and the nurse escorted Resident #48 back with no sign of injury. The Rehabilitation Director stated that Resident #48's exit was discussed in the morning meeting on the next day. The Rehabilitation Director stated that the Administrator leads those meetings and she talked about it that morning. The Rehabilitation Director stated that the occurrence was discussed by the Administrator, but she did not remember all that was said. The Rehabilitation Director stated that this most recent elopement occurred in early March. The Rehabilitation Director stated that she just happened to be coming out of her office, looked out through a big window to the Gazebo, and saw a nurse running quickly. The Rehabilitation Director stated that she observed Resident #48 over towards the far left corner of the area and Resident #48 was sitting down near the fence. The Rehabilitation Director stated that she believes that Resident #48 got out through the dining

room. The Rehabilitation Director was asked if Resident #48 would be safe out in the community. The Rehabilitation Director replied absolutely not.

32. Progress notes regarding Resident #40 were reviewed. A note, dated 3/7/21 at 7:16 AM and written by Staff J, indicated that Resident #40 was found wandering in the parking lot by a staff member. According to that note, Resident #40 was brought safely back inside. According to that note, another staff member assisted Resident #40 to Resident #40's room and informed a nurse of Resident #40 wandering. According to that note, the nurse assessed Resident #40, noted no injury, and Resident #40 was alert and oriented to baseline. According to that note, the nurse educated Resident #40 on safety. According to that note, Resident #40 apologized and stated that he or she understood. According to that note, when asked, Resident #40 said that he or she wanted to go outside. According to that note, Resident #40 was asked what door he or she used. According to that note, Resident #40 said that he or she went out one of the back doors. According to that note, Resident #40 was asked which back door. According to that note, Resident #40 said that that there are too many doors to remember and that he or she did not know which one. According to that note, a nurse and other staff members did not hear a door alarm when Resident #40 was found and brought back inside. According to that note, a note was placed in the Advanced Practice Registered Nurse communication book for wandering. According to that note, the oncoming shift nurse was informed of that wandering incident. According to that note, a resident aide was instructed to check on Resident #40 more frequently. According to that note, attempts x3 were made to contact the Director of Nursing.

33. The Facility's Adverse Event log was reviewed. No documentation was found in that log regarding a reported elopement event involving Resident #40.

34. Resident #40's medical record was reviewed. An Elopement Risk Observation

assessment (dated 3/3/21) was found for Resident #40. According to that assessment, Resident #40 had a score of 9, which indicates that Resident #40 was at moderate risk for elopement. According to that assessment, interventions include: three-day monitoring, four weeks behavioral management program to determine appropriate interventions after three-day evaluations, and quarterly assessments. According to that assessment, if significant change occurs or wandering persists, follow recommendations for high risk. A care plan, dated 2/15/21 and last reviewed 4/29/21, for Resident #40 was reviewed. According to that plan, Resident #40 has the potential for elopement related to wandering behaviors. That plan lists a goal of Resident #40 not sustaining any injuries related to wandering through the next review date. That plan includes an intervention of ensuring that basic needs are met when exhibiting behaviors, such as eating, drinking, and incontinent care. The additional interventions listed in Resident #40's Elopement Risk Observation assessment were not listed in Resident #40's care plan. An annual Minimum Data Set assessment for Resident #40 was reviewed. According to that assessment, Resident #40 had a Brief Interview for Mental Status (BIMS) score of 12 (which indicates moderate cognitive impairment). According to that assessment, Resident #40 required supervision with activities of daily living and ambulation and Resident #40 was not steady in balance but could stabilize without assistance.

35. On 4/21/21 at approximately 5:02 PM, an interview was conducted with the Facility's Risk Manager. The Risk Manager was asked at what point a resident is placed in the elopement book at the front desk. The Risk Manager replied that they are not placed in the elopement book until they are deemed high risk. Resident #40 was given a moderate risk on the last Minimum Data Set assessment. The Risk Manager stated that they would perform the Elopement Risk Observation. A copy of the Elopement Risk Observation was given to the

Agency's Surveyor for review. The Risk Manager stated that Resident #40 was allowed to go outside, and that Resident #40 goes outside frequently, especially into the courtyard (an open area at the back of the Facility with a gazebo and chairs). The Risk Manager stated that Resident #40's wandering has increased lately while Resident #40 has been ill.

36. On 4/21/21 at approximately 10:59 AM, an interview was conducted with the Facility's Administrator. The Administrator stated that her understanding of an elopement was exiting the building and off of the compound and if they were not able to find the resident. The Administrator was asked if she had any concerns if a resident makes it out of the building unwitnessed and ends up in the parking lot without an escort. The Administrator replied that if they are observed and returned to the building, she does not consider it an elopement.

37. On 4/22/21 at approximately 3:48 PM, an interview was conducted with the Facility's Director of Social Work. The Director of Social Work validated that Resident #40 had not been placed on the four-week Behavioral Management program as a result of the Elopement Risk assessment performed on 3/3/21. The Director of Social Work stated that Resident #40 was placed on the program following the notification of Resident #40 wandering into other resident rooms and that was on approximately 3/19/21.

38. On 4/22/21 at approximately 1:15 PM, an interview was conducted with Staff E (a Registered Nurse) and Staff F (a Registered Nurse Unit Manger). Staff E and F were asked how they know an exit door has been accessed. They pointed to a panel on the nurse alarm system and stated that it goes off and tells them the part of the building. Staff F stated that they are all to head in the direction of the alarm. Staff E and F were asked what they would do if they found a resident outside. Staff F stated that they would redirect the resident back into the Facility, ensure that the resident was safe with no injuries, and notify the Risk Manager and the Director of

Nursing. Staff E and F were asked how staff know a resident is an elopement risk. Staff F stated that they have a book with high-risk elopement residents. Staff F stated that all staff are aware of who is high risk and who needs watching. Staff F stated that Activities works to engage residents, so they do not wander.

39. On 4/23/21 at approximately 11:07 AM, an interview was conducted with the Nurse Practitioner. The Nurse Practitioner stated that Resident #40 is one of her patients. The Nurse Practitioner stated that she was aware that Resident #40 had started exit-seeking behaviors over the last couple of weeks. The Nurse Practitioner stated that she documented on 3/9/21 that Resident #40 exited the Facility and made it to the parking lot. The Nurse Practitioner stated that at that point Resident #40 had not had any falls. The Nurse Practitioner stated that she ordered some laboratory tests to rule out urinary tract infection for this new behavior. The Nurse Practitioner stated that she did not see Resident #40 on 3/9/21. The Nurse Practitioner stated that Resident #40 told her that he or she was trying to get to the store. The Nurse Practitioner stated that she asked Resident #40, and Resident #40 did not remember getting out of the Facility. The Nurse Practitioner stated that staff said that Resident #40 was trying to get to a hardware store, Resident #40 said this multiple times, and Resident #40 is still saying that. The Nurse Practitioner stated that Resident #40's tests were all within normal limits. The Nurse Practitioner stated that she saw Resident #40 on 3/22/21 for altered mental status and increased anxiety. The Nurse Practitioner stated that staff reported that Resident #40 was not sleeping. The Nurse Practitioner stated that she ordered tests again and adjusted Resident #40's medications.

40. The Facility failed to provide adequate supervision for residents with wandering and exit-seeking behaviors, by failing to ensure that two vulnerable residents at risk for elopement (Resident #40 and #48) were not able to exit the building unsupervised on 3/7/21

(Resident #40) and 3/9/21 (Resident #48).

41. This failure presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility and thus this deficient practice constitutes an isolated Class I deficiency.

42. The Agency cited the Respondent for an isolated class I deficiency.

43. On 4/23/21 at approximately 3:27 PM, the Facility's Administrator was notified of this Class I deficiency.

Sanction

44. Under Florida law, as a penalty for any violation of this part, authorizing statutes, or applicable rules, the Agency may impose an administrative fine. § 408.813(1), Fla. Stat. (2020).

45. Under Florida law,

> A class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. The condition or practice constituting a class I violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the agency, is required for correction. A class I deficiency is subject to a civil penalty of $10,000 for an isolated deficiency, $12,500 for a patterned deficiency, and $15,000 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last licensure inspection or any inspection or complaint investigation since the last licensure inspection. A fine must be levied notwithstanding the correction of the deficiency.

§ 400.23(8)(a), Fla. Stat. (2020).

46. Under Florida law, a conditional licensure status means that a facility, due to the presence of one or more class I or class II deficiencies, or class III deficiencies not corrected

within the time established by the agency, is not in substantial compliance at the time of the survey with criteria established under this part or with rules adopted by the Agency. § 400.23(7)(b), Fla. Stat. (2020).

47. Due to the presence of an isolated class I deficiency at the time of the survey, the Agency assigned the Respondent conditional licensure status with a beginning date and ending date as set forth above.

48. Under Florida law, a survey shall be conducted biannually [that is, once every six months] on a Facility that has been cited for a class I deficiency, has been cited for two or more class II deficiencies arising from separate surveys or investigations within a 60 day period, or has had three or more substantiated complaints within a six month period each resulting in at least one class I or class II deficiency. These biannual surveys are to continue until the facility has two consecutive licensure surveys without a citation for a Class I or a Class II deficiency. §400.19(3), Fla. Stat. (2020).

49. Under Florida law, in addition to any other fees or fines in Chapter 400 Part II, the Agency shall assess a fine for each facility that is subject to the six month survey cycle. The fine shall be $6,000. § 400.19(3), Fla. Stat. (2020).

WHEREFORE, the Agency seeks to impose against the Respondent, based upon an isolated class I deficiency: an administrative fine of $10,000.00; the assignment of conditional licensure status; and a six month survey cycle and $6,000.00 fine.

COUNT II
Risk Management & Quality Assurance Program Required

50. Under Florida law,

Every facility shall, as part of its administrative functions, establish an internal risk management and quality assurance program, the purpose of which is to assess resident care practices; review facility quality indicators, facility incident reports,

> deficiencies cited by the agency, and resident grievances; and develop plans of action to correct and respond quickly to identified quality deficiencies. The program must include:
> (a) A designated person to serve as risk manager, who is responsible for implementation and oversight of the facility's risk management and quality assurance program as required by this section.
> (b) A risk management and quality assurance committee consisting of the facility risk manager, the administrator, the director of nursing, the medical director, and at least three other members of the facility staff. The risk management and quality assurance committee shall meet at least monthly.
> (c) Policies and procedures to implement the internal risk management and quality assurance program, which must include the investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents to residents.
> (d) The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed health care facility to report adverse incidents to the risk manager, or to his or her designee, within 3 business days after their occurrence.
> (e) The development of appropriate measures to minimize the risk of adverse incidents to residents, including, but not limited to, education and training in risk management and risk prevention for all nonphysician personnel, as follows:
> 1. Such education and training of all nonphysician personnel must be part of their initial orientation; and
> 2. At least 1 hour of such education and training must be provided annually for all nonphysician personnel of the licensed facility working in clinical areas and providing resident care.
> (f) The analysis of resident grievances that relate to resident care and the quality of clinical services.

§ 400.147(1), Fla. Stat. (2020).

51. On or about April 19, 2021, to April 23, 2021, the Agency conducted a survey of the Facility.

52. Based on observation, interview, and record review, the Facility Quality Assurance and Performance Improvement (QAPI) process failed to develop and implement appropriate plans of action to correct identified quality deficiencies related to resident elopements that occurred on 3/7/21 (Resident #40) and 3/9/21 (Resident #48). The Facility's failure to follow the QAPI process may prevent the Facility from correcting and improving its

systems to ensure resident safety and prevent serious harm to each of the 28 residents in the Facility who were identified as at risk for elopement. The Facility's failure to prevent an elopement and eliminate potential hazards placed two residents (Resident #40 and #48) at an increased likelihood of serious injury and death. An eloped resident is at risk for being injured or killed, for example, by cars on the highly traveled Berryhill Road (which is approximately .4 miles south of the Facility), by falling and injuring themselves, or by drowning in a holding pond (there are holding ponds located south of the Facility).

53. Resident #48's medical record was reviewed. According to an Event Report, dated 3/9/21, the resident was found unattended outside the Facility sitting on a bag of sand on 3/9/21. An Elopement Risk Observation form, dated 2/24/21, for Resident #48 was reviewed. According to that form, Resident #48 received a score of 17 indicating that Resident #48 was at high risk for elopement. The Elopement Risk Observation form is the Facility's internal elopement risk assessment tool.

54. On 4/21/21 at approximately 10:37 AM, an interview was conducted with the Facility's Risk Manager. The Risk Manager stated that she remembered Resident #48's elopement. The Risk Manager stated that they made an announcement, and all staff went room to room checking for the resident. The Risk Manager stated that she, the Facility's Clinical Care Coordinator, and the Facility's Director of Therapy checked the outside grounds and found the resident sitting on a bag of sand leaning up against a fence. The Risk Manager stated that she felt that the resident had gone through the dining room door. The Risk Manager stated that the Facility had fire safety doors which will open if you keep pushing on them. The Risk Manager was asked how the Facility was made aware that Resident #48 was out of the building. The Risk Manager replied that they received a call from a neighbor who was behind their fence-line, and

the neighbor wanted to make sure that Resident #48 was okay and should be out there. The Risk Manager stated that there was an alarm on the door. The Risk Manager stated that the alarm sounds on the door itself, but it is hooked to the whole system so you can hear it throughout the building. The Risk Manager stated that the alarm had been silenced because, when the staff member checked to see why the door was going off, Resident #48 was not in sight. The Risk Manager stated that Resident #48 got away from the door quicker than someone could get to the area to see Resident #48, so they were under the understanding that everything was clear. The Risk Manager stated that a person from the neighborhood let them know that Resident #48 was out there. The Risk Manager was asked for the incident investigation with the root cause analysis. The Risk Manager replied that the investigation should be in the computer in progress notes. The Risk Manager stated that she would check in her filing system. The Risk Manager stated that she wrote it out in the Elopement Drill form because it is what she is most familiar with. The Risk Manager stated that there was also an in-service, titled Disaster Preparedness Drill, which had nine signatures on it. The Risk Manager was asked for a copy of the incident report and a copy of the investigation with root cause analysis. However, neither of those documents was provided during this survey.

55. On 4/22/21, Resident #40's medical record was reviewed. A progress note, written on 3/7/21 at 7:16 AM by Staff J (a Registered Nurse), regarding Resident #40 was reviewed. According to that note, Resident #40 was found wandering in the parking lot by another Facility staff member. According to that note, the nurse attempted to contact the Director of Nursing three times. An Elopement Risk Observation form, performed on 3/3/21, was found regarding Resident #40. According to that form, Resident #40 had a score of 9 which indicates that Resident #40 was at moderate risk for elopement.

56. The Facility's Adverse Event log was reviewed. No documentation was found in that log regarding an elopement event involving Resident #40.

57. The Facility's elopement book was reviewed. Resident #40 was not identified in that book as an elopement risk.

58. On 4/21/21 at approximately 5:02 PM, an interview was conducted with the Risk Manager. The Risk Manager was asked if she recalled an event where Resident #40 was found outside the Facility on 3/7/21. The Risk Manager indicated that she did not recall an elopement. The Agency's Surveyor reviewed Resident #40's medical record with the Risk Manager and pointed out the documentation on 3/7/21 regarding Resident #40 being brough in from the parking lot. The Risk Manager stated that this event was not brought to her attention. The Risk Manager stated that she had not performed an investigation.

59. On 4/22/21 at approximately 1:11 PM, an interview was conducted with Staff W (a Licensed Practical Nurse) and Staff X (a Certified Nursing Assistant). Staff W and Staff X were asked if they had in-services for elopement. Staff W and Staff X replied that they had online training. Staff W and Staff X were asked if they had been part of an elopement drill. Staff W and Staff X replied that they had not been part of a drill and could not described a drill.

60. On 4/23/21 at approximately 11:58 AM, an interview was conducted with Staff F (a Certified Nursing Assistant). Staff F stated that she was not aware of an elopement book. Staff F stated that she finds out about elopement risks through shift reports. Staff F was asked how elopement education is provided. Staff F replied that there was education provided on elopement, but she also stated that she did not recall how often and that she could not remember the last time that it was done.

61. On 4/23/21 at approximately 9:44 AM, an interview was conducted with Staff C (a Certified Nursing Assistant). Staff C indicated being there for five years and not having an elopement drill. Staff C indicated having education on elopement, but not participating in a drill.

62. On 4/23/21 at approximately 10 AM, an interview was conducted with Registered Nurse E. Registered Nurse E indicated having been there for less than three months. Registered Nurse E indicated being given a front door code during orientation, that it was still the same door code, and that it has not been changed. Registered Nurse E indicated not having any drills since being hired. Registered Nurse E indicated receiving some education and a handout regarding elopement.

63. On 4/23/21 at approximately 2:18 PM, an interview was conducted with the Facility's Rehabilitation Director. The Rehabilitation Director indicated not having participated in any type of physical drill for two and a half years.

64. On 4/22/21 at approximately 1:33 PM, an interview was conducted with the Facility's Administrator and the Facility's Risk Manager regarding staff training on elopement. The Administrator and the Risk Manager are two members of the Facility's QAPI committee. The Administrator stated that the Risk Manager was performing the in-services on Code Pink at the direction of the Administrator. It was indicated that there is an emergency announcement which uses a color system to identify Facility emergencies and that pink is used to identify a missing resident. The Administrator stated that the form that they use has a space for a topic/subject, date, and signatures. It was indicated that, in this case, the Risk Manager had pulled the wrong form. The Administrator stated that the Risk Manager documented the elopement of Resident #48 as an effective elopement drill. The Administrator stated that staff responded appropriately, and the resident had no ill effects. The Administrator stated that she

thinks that in all reality that, for her first drill, she did a good job on the paper and assessing the compliance. The Administrator stated that they all took their action steps and they all checked for safety and security. The Administrator stated that she would use it as a drill. The Administrator agreed that the situation was not a preplanned drill. The Administrator agreed that nothing provided to the Surveyors at that time included a root cause analysis of how the resident was able to elope from the building. The Administrator verified that she was the person responsible for the oversight of the Risk Manager and responsible for reviewing the Risk Manager's work to determine if it was completed correctly. The Administrator stated that she was responsible for following up on the Risk Manager's performance and making a plan of correction for the elopements.

65. On 4/23/21 at approximately 3:42 PM, an interview was conducted with the Facility's Administrator and the Facility's Risk Manager regarding the QAPI program. The Surveyor asked about performance improvement projects. The Administrator stated that they look at the normal things, such as antibiotic usage and falls. The Administrator stated that they have quite a few systems that track data that they utilize. The Administrator stated that some of it is reports that they receive from corporate, and some is data that they track. The Administrator stated that adverse events are tracked for trends. The Administrator and the Risk Manager were asked if the Facility had anything in way of performance improvement plans or investigations related to elopements. The Administrator replied that the only incident was the Code Pink that they had for Resident #48 in March of 2021.

66. The Facility's QAPI plan was reviewed. That plan lists various data sources that are utilized for QAPI meetings. In the feedback, data system and monitoring section of that plan, it indicates that the Facility will maintain a method for tracking and monitoring adverse events

that will be investigated every time they occur, in order to implement interventions to prevent recurrence.

67. A Facility policy document titled Missing Resident (effective date 9/1/12 and last reviewed/revised date 6/1/17) was reviewed. That document indicates that one of the items to be completed when a resident is located and/or on the return of the resident to the Facility is, within 24 hours of the incident, an Incident Report Form shall be completed indicating the results of the Facility's investigation of the incident and any corrective measures implemented. That document indicates that another item to be completed when a resident is located and/or on the return of the resident to the Facility is that the resident's care plan shall be reviewed and revised as needed. That document indicates that another item to be completed when a resident is located and/or on the return of the resident to the Facility is that all missing resident incidents shall be reviewed as part of the Facility's Performance Improvement Program.

68. A Facility policy document titled Occurrences (effective date 7/1/12, revised date 5/4/16, and reviewed date 9/9/19) was reviewed. According to that document, an elopement is one type of occurrence hazard. According to that document, a licensed nurse will be responsible for completing occurrence documentation requirements prior to the end of the shift when the occurrence took place. That document indicates that, as part of investigation and follow-up, the Administrator or designee will complete the supervisor investigation on all occurrences, and report to the appropriate state agency and/or external agencies according to law. According to that document, the log is to be reviewed by the QAPI Committee and documented in minutes.

69. The Facility Quality Assurance and Performance Improvement (QAPI) process failed to develop and implement appropriate plans of action to correct identified quality deficiencies related to resident elopements that occurred on 3/7/21 (Resident #40) and 3/9/21

(Resident #48).

70. This failure presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility and thus this deficient practice constitutes an isolated Class I deficiency.

71. The Agency cited the Respondent for an isolated class I deficiency.

72. On 4/23/21 at approximately 3:27 PM, the Facility's Administrator was notified of this Class I deficiency.

Sanction

73. Under Florida law, as a penalty for any violation of this part, authorizing statutes, or applicable rules, the Agency may impose an administrative fine. § 408.813(1), Fla. Stat. (2020).

74. Under Florida law,

> A class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. The condition or practice constituting a class I violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the agency, is required for correction. A class I deficiency is subject to a civil penalty of $10,000 for an isolated deficiency, $12,500 for a patterned deficiency, and $15,000 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last licensure inspection or any inspection or complaint investigation since the last licensure inspection. A fine must be levied notwithstanding the correction of the deficiency.

§ 400.23(8)(a), Fla. Stat. (2020).

75. Under Florida law, a conditional licensure status means that a facility, due to the presence of one or more class I or class II deficiencies, or class III deficiencies not corrected

within the time established by the agency, is not in substantial compliance at the time of the survey with criteria established under this part or with rules adopted by the Agency. § 400.23(7)(b), Fla. Stat. (2020).

76. Due to the presence of an isolated class I deficiency at the time of the survey, the Agency assigned the Respondent conditional licensure status with a beginning date and ending date as set forth above.

77. Under Florida law, a survey shall be conducted biannually [that is, once every six months] on a Facility that has been cited for a class I deficiency, has been cited for two or more class II deficiencies arising from separate surveys or investigations within a 60 day period, or has had three or more substantiated complaints within a six month period each resulting in at least one class I or class II deficiency. These biannual surveys are to continue until the facility has two consecutive licensure surveys without a citation for a Class I or a Class II deficiency. §400.19(3), Fla. Stat. (2020).

78. Under Florida law, in addition to any other fees or fines in Chapter 400 Part II, the Agency shall assess a fine for each facility that is subject to the six month survey cycle. The fine shall be $6,000. § 400.19(3), Fla. Stat. (2020).

WHEREFORE, the Agency seeks to impose against the Respondent, based upon an isolated class I deficiency: an administrative fine of $10.000.00; the assignment of conditional licensure status; and a six month survey cycle and $6,000.00 fine.

CLAIM FOR RELIEF

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, respectfully seeks an order that:

1. Makes findings of fact and conclusions of law in favor of the Agency.

2. Imposes sanctions against the Respondent as set forth above.

Respectfully Submitted,

Maurice Boetger

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NOTICE

Pursuant to Section 120.569, F.S., any party has the right to request an administrative hearing by filing a request with the Agency Clerk. In order to obtain a formal hearing before the Division of Administrative Hearings under Section 120.57(1), F.S., however, a party must file a request for an administrative hearing that complies with the requirements of Rule 28-106.2015, Florida Administrative Code. Specific options for administrative action are set out in the attached Election of Rights form.

The Election of Rights form or request for hearing must be filed with the Agency Clerk for the Agency for Health Care Administration within 21 days of the day the Administrative Complaint was received. If the Election of Rights form or request for hearing is not timely received by the Agency Clerk by 5:00 p.m. Eastern Time on the 21st day, the right to a hearing will be waived. A copy of the Election of Rights form or request for hearing must also be sent to the attorney who issued the Administrative Complaint at his or her address. The Election of Rights form shall be addressed to: Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 3, Tallahassee, FL 32308; Telephone (850) 412-3630, Facsimile (850) 921-0158.

Any party who appears in any agency proceeding has the right, at his or her own expense, to be accompanied, represented, and advised by counsel or other qualified representative. Mediation under Section 120.573, F.S., is available if the Agency agrees, and if available, the pursuit of mediation will not adversely affect the right to administrative proceedings in the event mediation does not result in a settlement.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the Administrative Complaint and Election of Rights form were served to the individuals named below by the method designated on this 27 day of August, 2021.

Maurice Boetger

Maurice T. Boetger, Senior Attorney
Florida Bar No. 0125192
Office of the General Counsel
Agency for Health Care Administration
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Administrator Pruitthealth-Santa Rosa 5530 Northrop Road Milton, Florida 32570 (Certified U.S. Mail)	Administrator Pruitthealth-Santa Rosa 1626 Jeurgens Court Norcross, Georgia 30093 (Certified U.S. Mail)

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STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

Re: Pruitthealth-Santa Rosa, LLC d/b/a Pruitthealth-Santa Rosa **AHCA No. 2021007954**

ELECTION OF RIGHTS

This Election of Rights form is attached to an Administrative Complaint. It may be returned by mail or facsimile transmission, but must be received by the Agency Clerk within 21 days, by 5:00 pm, Eastern Time, of the day you received the Administrative Complaint. If your Election of Rights form or request for hearing is not received by the Agency Clerk within 21 days of the day you received the Administrative Complaint, you will have waived your right to contest the proposed agency action and a Final Order will be issued imposing the sanction alleged in the Administrative Complaint.

(Please use this form unless you, your attorney or your representative prefer to reply according to Chapter120, Florida Statutes, and Chapter 28, Florida Administrative Code.)

Please return your Election of Rights form to this address:

Agency for Health Care Administration
Attention: Agency Clerk
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308
Telephone: 850-412-3630 Facsimile: 850-921-0158

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

OPTION ONE (1) _______ I admit to the allegations of fact and conclusions of law alleged in the Administrative Complaint and waive my right to object and to have a hearing. I understand that by giving up the right to object and have a hearing, a Final Order will be issued that adopts the allegations of fact and conclusions of law alleged in the Administrative Complaint and imposes the sanction alleged in the Administrative Complaint.

OPTION TWO (2) _______ I admit to the allegations of fact alleged in the Administrative Complaint, but wish to be heard at an informal proceeding (pursuant to Section 120.57(2), Florida Statutes) where I may submit testimony and written evidence to the Agency to show that the proposed agency action is too severe or that the sanction should be reduced.

OPTION THREE (3) _____ I dispute the allegations of fact alleged in the Administrative Complaint and request a formal hearing (pursuant to Section 120.57(1), Florida Statutes) before an Administrative Law Judge appointed by the Division of Administrative Hearings.

PLEASE NOTE: Choosing OPTION THREE (3), by itself, is NOT sufficient to obtain a

formal hearing. You also must file a written petition in order to obtain a formal hearing before the Division of Administrative Hearings under Section 120.57(1), Florida Statutes. It must be received by the Agency Clerk at the address above **within 21 days** of your receipt of this proposed agency action. The request for formal hearing must conform to the requirements of Rule 28-106.2015, Florida Administrative Code, which requires that it contain:

1. The name, address, telephone number, and facsimile number (if any) of the Respondent.
2. The name, address, telephone number and facsimile number of the attorney or qualified representative of the Respondent (if any) upon whom service of pleadings and other papers shall be made.
3. A statement requesting an administrative hearing identifying those material facts that are in dispute. If there are none, the petition must so indicate.
4. A statement of when the respondent received notice of the administrative complaint.
5. A statement including the file number to the administrative complaint.

Mediation under Section 120.573, Florida Statutes, may be available in this matter if the Agency agrees.

Licensee Name: ____

Contact Person: ______________________________ Title: ______________

Address: ____
Number and Street City Zip Code

Telephone No. ______________________ Fax No. ______________________

E-Mail (optional) ____

I hereby certify that I am duly authorized to submit this Election of Rights form to the Agency for Health Care Administration on behalf of the licensee referred to above.

Signed: ______________________________ Date: ______________

Printed Name: ______________________________ Title: ______________

RECEIVED
GENERAL COUNSEL
SEP 07 2021
Agency for Health Care Administration

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

Pruitthealth-Santa Rosa, LLC
Pruitthealth-Santa Rosa

AHCA No. 2021007954

ELECTION OF RIGHTS

This Election of Rights form is attached to an Administrative Complaint. It may be returned by mail or facsimile transmission, <u>but must be received by the Agency Clerk within 21 days, by 5:00 pm, Eastern Time, of the day you received the Administrative Complaint.</u> If your Election of Rights form or request for hearing is not received by the Agency Clerk within 21 days of the day you received the Administrative Complaint, you will have waived your right to contest the proposed agency action and a Final Order will be issued imposing the sanction alleged in the Administrative Complaint.

(Please use this form unless you, your attorney or your representative prefer to reply according to Chapter120, Florida Statutes, and Chapter 28, Florida Administrative Code.)

Please return your Election of Rights form to this address:

Agency for Health Care Administration
Attention: Agency Clerk
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308
Telephone: 850-412-3630 Facsimile: 850-921-0158

<u>PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS</u>

OPTION ONE (1) __✓___ I admit to the allegations of fact and conclusions of law alleged in the Administrative Complaint and waive my right to object and to have a hearing. I understand that by giving up the right to object and have a hearing, a Final Order will be issued that adopts the allegations of fact and conclusions of law alleged in the Administrative Complaint and imposes the sanction alleged in the Administrative Complaint.

OPTION TWO (2) _______ I admit to the allegations of fact alleged in the Administrative Complaint, but wish to be heard at an informal proceeding (pursuant to Section 120.57(2), Florida Statutes) where I may submit testimony and written evidence to the Agency to show that the proposed agency action is too severe or that the sanction should be reduced.

OPTION THREE (3) _____ I dispute the allegations of fact alleged in the Administrative Complaint and request a formal hearing (pursuant to Section 120.57(1), Florida Statutes) before an Administrative Law Judge appointed by the Division of Administrative Hearings.

<u>PLEASE NOTE</u>: Choosing OPTION THREE (3), by itself, is <u>NOT</u> sufficient to obtain a

formal hearing. You also must file a written petition in order to obtain a formal hearing before the Division of Administrative Hearings under Section 120.57(1), Florida Statutes. It must be received by the Agency Clerk at the address above **within 21 days** of your receipt of this proposed agency action. The request for formal hearing must conform to the requirements of Rule 28-106.2015, Florida Administrative Code, which requires that it contain:

1. The name, address, telephone number, and facsimile number (if any) of the Respondent.
2. The name, address, telephone number and facsimile number of the attorney or qualified representative of the Respondent (if any) upon whom service of pleadings and other papers shall be made.
3. A statement requesting an administrative hearing identifying those material facts that are in dispute. If there are none, the petition must so indicate.
4. A statement of when the respondent received notice of the administrative complaint.
5. A statement including the file number to the administrative complaint.

Mediation under Section 120.573, Florida Statutes, may be available in this matter if the Agency agrees.

Licensee Name: Charles W. Jackson JR.

Contact Person: Charles Jackson Title: AdministratoR

Address: 5530 Northop Rd Milton, FL 32570
Number and Street City Zip Code

Telephone No. (850) 983-8888 Fax No. (850) 983-8880

E-Mail (optional) cwjackson@pruitthecth.com / SN048@pruitthealth.com

I hereby certify that I am duly authorized to submit this Election of Rights form to the Agency for Health Care Administration on behalf of the licensee referred to above.

Signed: Charles W. Jackson Jr. Date: 8/31/21

Printed Name: Charles W. Jackson JR. Title: administratoR