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
	AL11967383	A. BUILDING: _____ B. WING _____	11/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TROPICAL LIVING CLUB 2	320 FORTENBERRY ROAD MERRITT ISLAND, FL 32952

(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 Complaint Investigation #2019011246 was conducted at on , and . Tropical Living Club 2 had a deficiency at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 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 resident diets in accordance with rule 58A-5.020, 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.	A 025		

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A 025	Continued From page 1 (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 record review, facility documentation and interview, the facility failed to provide appropriate supervision by not maintaining a general awareness and the whereabouts at all times, during an incident requiring local Law Enforcement to be notified for a newly admitted resident who had [illegible] (#1). Findings: Resident #1's record revealed an admission date [illegible]. An 1823 Health Assessment dated [illegible] reflected the resident had [illegible] damage due to [illegible] and required assistance with self-administration of medications. A request for [illegible] was documented on the 1823 Health Assessment. Photographic evidence obtained. On [illegible] at 9:30 AM, resident #1 eloped from the facility one month after admission. Facility documentation revealed that earlier that morning resident #1 was observed on an upsetting telephone call with a family member and was very	A 025		

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A 025	Continued From page 2	A 025		

agitated because he thought he was in a jail and wanted to visit his son in another state for his son's birthday. Caregiver B stated that he hung up the phone and went outside the gated courtyard area. The facility did not supervise the resident at this time and did not document that the caregiver offered support and nurturing techniques to calm resident #1 after observing the upsetting phone call. At 9:40 AM, caregiver B went to check outside for the resident could not find him anywhere outside. Caregiver B called the Brevard County Sheriff's Office to inform them that resident #1 was missing. At 11:50 AM, approximately 2 hours later, resident #1 was returned to the facility by the Brevard County Sheriff's Deputy. He was found about one mile from the facility at a restaurant. The Department of Children and Families (DCF) was also notified.

On . . . . . at 10:10 AM, an interview with caregiver A confirmed he was working on when resident #1 eloped from the facility. He said he witnessed resident #1 very upset on the telephone conversation and hung up the phone.

On at 1 PM, an interview with caregiver B confirmed she was working on when resident #1 eloped from the facility. She said she witnessed resident #1 very angry and upset on the telephone call, he hung up the phone, and went outside to the gated courtyard area. Caregiver B confirmed she called law enforcement after searching the facility and surroundings for 10 minutes and was not able to locate resident #1.

On at 4 PM, the Administrator confirmed the findings, and agreed that the elopement occurred.

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A 025	Continued From page 3 Class II	A 025		