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
	AL11966952	A. BUILDING: _____ B. WING _____	11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC HOUSE	1770 S LILAC CIRCLE TITUSVILLE, FL 32796

(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 #2019011830 was conducted on [redacted] and on [redacted] at the Lilac House, Titusville. Deficiencies were found at the time of the visit.	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 [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. 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 observation, record reviews and interview the facility failed to maintain a general awareness of a resident's whereabouts for 1 out of 6 sampled residents (Resident#1) and failed to update the resident's health assessment by a medical health professional. Findings: Review of the Adverse Incident report dated [redacted], documents Resident#1 on [redacted] around 11am asked the staff to sit outside on the front porch. Staff left the resident on the porch unattended and went into the home. Approximately 11:45 a.m., the staff went outside to check on the resident and he was not found. Staff then checked the inside of the home and he was not located. Staff then called Resident#1's family, the administrator and the local police per the facility policy. The staff reports the Resident was not found by local police on approximately 10:30 a.m. several miles away with no identification or possession of funds.	A 025		

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A 025	Continued From page 2 Review of the local law enforcement report reflected that law enforcement was called to investigate an elopement for resident #1 on [redacted] at 1:18 p.m. Law enforcement searched the immediate area for the resident and could not locate him. Staff at the local law enforcement state there is no further documentation of where, when or what condition the resident was in when found and brought to the facility. Resident#1's health assessment for (1823) dated [redacted], revealed the resident has a history of [redacted], requires a walker for ambulation and is on precaution. The 1823 was not updated to reflect he was an elopement risk, revealed a Bi Polar [redacted] and [redacted], and requires a walker for ambulation and precaution. The 1823 was not updated to reflect elopement risk. Review of the Department of Children and Families (DCF) investigative report, confirms the staff and administrator were aware of the resident's high risk for elopement previous behavior. The DCF report is substantiated for lack of supervision. During an observation of Resident#1 on [redacted] at 11am, the resident did not have any identification on his person and was ambulating with a walker. He was not able to be interviewed due to his cognition. On [redacted] at 12 P.m. staff A confirmed the findings and stated the resident did not have any identification on his person or monitoring system in place. Class II	A 025		

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A 032 SS=D	58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(i) Resident Care - Elopement Standards 58A-5.0182 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 58A-5.0181(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 58A-5.0191(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed as high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative.	A 032		

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A 032	Continued From page 4 (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(l), F.S. 429.41(1)(a)3 & 3(l),FS 3. Resident elopement requirements.-Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures. (l) The establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement	A 032		

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A 032	Continued From page 5 drills each year. All administrators and direct care staff shall participate in the drills. Facilities shall document the drills. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to make a daily effort to determine that 1 out of 6 sampled residents (Resident#1) who was at risk for elopement had identification (ID) on their person that included their name and the facility's name, address and telephone number and did not update the resident's health assessment to reflect changes in condition. Findings: 1. On a record review of the Adverse Incident report dated , documents Resident#1 on around 11am asked the staff to sit outside on the front porch. Staff left the resident on the porch unattended and went into the home. Approximately 11:45 the staff went outside to check on the resident and he was not found. Staff then checked the inside of the home and he was not located. Staff then called Resident#1's family, the administrator and the local police per the facility policy. Resident was not found by local police until approximately 10:30am several miles away with no identification or possession of funds. 2. Observations made on at 11am revealed Resident#1 did not have ID on his person. 3. A record review of Resident#1's 1823 health assessment dated was not updated to reflect the resident is at risk for elopement.	A 032		

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A 032	Continued From page 6 4. In a review of the facility's corrective action it states the staff will be re trained in elopement procedures and policies and the resident with risk for elopement wil have an ID or monitoring device on them at all times. 5. In an interview on . . . . . at 11am with the manager, she confirmed the findings and stated she did not have any documentation for the re-training of staff and she was not aware if Resident#1 will be getting any type of identification or monitoring system at this time. She also confirmed she was not aware why the 1823 was not updated to reflect Resident#1 as an elopment risk. Class III	A 032		