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 _____	05/07/2020

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 Complaint Investigation #2020007655 was conducted on [redacted] and 7, 2020. Tropical Living Club 2 had deficiencies at the time of the visit.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(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] or [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. 59A-36.007 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 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 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 reviews and interview, the facility failed to provide care and services appropriate to the needs, including maintaining a general awareness of the resident's whereabouts of 1 of 8 residents who eloped from the facility (#1). Findings: Resident #1's record revealed he was admitted to the facility on [redacted]. His current health assessment (form 1823) was dated [redacted] and included diagnoses of [redacted] damage due to [redacted] and [redacted]. He required assistance with self-administration of medications. He required supervision with some activities of daily living (ADLs), grooming, [redacted], and eating, but was independent with all other ADLs. He was noted to be at risk for elopement. The record revealed he had one previous elopement on [redacted] that required the County Sheriff's assistance to find him. An incident report, dated [redacted] at 8:15 AM,	A 025		

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A 025	Continued From page 2 noted facility staff were unable to locate resident #1. After knocking on his door, staff A entered the room to find the window open and the window screen on the bed. Staff A started the elopement procedures, searched the facility and facility grounds and then called 911 at 8:30 AM. The incident report noted resident #1 had no signs or complaints of injury upon return. An incident log, dated , from the County Sheriff's office noted that they were alerted and began a search using the GPS tracker, bloodhounds, vehicle units and a helicopter. Resident #1 was located at 9:44 AM about 6 miles from the facility at the intersection of Routes 528 and US 1. To get to that location, the resident needed to cross many intersections and a bridge over the Indian River to the mainland. He was returned to the facility at 10:40 AM. On . . . . . at 11:30 AM, staff A stated he was the overnight caregiver on the /2020 shift. Staff A last saw resident #1 around 10 PM when he went to bed. Staff A stated he sleeps in the facility and keeps the door open to hear residents if they are up at night. At 2 AM on , he got up to help another resident to the restroom. At that time, he did not see anyone else up or hear any unusual noise. He got up again at 6:30 AM and started the coffee. He stated the residents get up at different times, but most come out for coffee and breakfast by about 8 AM. At 8:15 AM while passing medications, he said staff B told him resident #1 was not out of his room yet. Staff A went to knock on his door. When there was no answer, he got the master keys and again knocked while unlocking the door to resident #1's room. He said he saw the window was open and the window screen was on the resident's bed. Most of the vertical slats were on the floor.	A 025		

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A 025	Continued From page 3 Staff A said he alerted staff B, who said she also had not seen him. Staff A and B started a search of all rooms and bathrooms in the facility. Staff A searched the facility grounds. He said he called 911 at about 8:30 AM and called the administrator. He stated resident #1 wore an ankle bracelet with a GPS that was placed by the County Sheriff. He said the battery in the GPS unit was . . . . and the Sheriff used search dogs to help find the resident. On at 12 PM, staff B confirmed she was scheduled to work on . . . . . from 7 AM-3 PM. She said she arrived a little early and saw a few residents up and walking around. She started making breakfast. She said a little after 8 AM, she noticed resident #1 had not come out of his room for breakfast and told Staff A. She said after it was found he was missing, she helped search inside the facility and then stayed with the other residents while the search continued. She stated resident #1 was returned later that morning and she brought his lunch to him in his room, since he needed to stay . . for 14 days due to the Covid-19 . . pandemic. She reported he had no complaints and followed the isolation rules. She said there is an alarm on his door and window now, so they know when he comes out into the hall to go to the bathroom. She stated she hadn't noticed any unusual behaviors prior to his elopement. On . . . . . at 12:30 PM, the administrator stated she was in the facility on until about 10 PM. She said she saw resident #1 shortly before she left, and he was going to bed. She stated he had no unusual behaviors in the days leading up to the elopement on and seemed content and happy. She confirmed this was resident #1's second elopement. The	A 025		

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A 025	Continued From page 4	A 025		

first occurred in . . . . . , a few weeks after he was admitted. She said at that time, he was angry at "being dumped" there and had not acclimated to living in the facility yet. She said since that time, he had adjusted very well, and got along with everyone. She said he mainly kept to himself but had his meals with everyone. She stated he had not ever tried anything like this before. The administrator said she was called when staff A realized resident #1 was missing. She came to the facility as quickly as possible. The County Sheriff deputy had arrived, conducted a search of the building and the immediate area. She said they were unable to locate the resident using the GPS ankle bracelet they had placed on him because it appeared the battery was . This statement is contrary to what the deputy said.They brought dogs with them instead. The County Sheriff deputy said the GPS monitor was also used to locate the same resident for the elopement in . . . . . . They searched and found him about 6 miles away, unharmed, and returned him to the facility. She said they have confined him to his room since his return because they had no idea who he encountered while he was out. He will remain in his room for 14 days, except for supervised bathroom trips. She confirmed there were alarms installed on his window and door following this incident. She also stated the physician for resident #1 called and said there would be no changes needed to his medications.

The facility is conducting "resident checks" daily at 9 AM, 3 PM and 9 PM for all residents and had been for several months. The logs for , and , ... were reviewed.

On . . . . . at 2:50 PM, in a phone interview with the deputy working with the GPS ankle

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A 025	Continued From page 5 monitor program, he stated the ankle bracelet had been placed by the County prior to the resident being admitted to the facility last Spring 2019. He stated the County changes the batteries in the monitor every 60 days and was last changed on . He said the facility has a small black matchbox they were to use for daily battery checks. He stated the GPS monitor was used to locate resident #1 on . He said the GPS monitor was also used to locate the same resident for the elopement in . He further stated they only place the bracelets on people in private homes who meet certain criteria. The GPS program agreed to let resident #1 keep the monitoring bracelet on him after admission to the facility until he adjusted to being in the assisted living facility. He stated when the resident eloped within the first month of living there, the program agreed again to let him continue to wear the GPS bracelet. It was ten hours before the facility staff were aware that resident #1 had eloped from the facility. The facility did not put any interventions in place when the resident eloped on . The intervention that was put in place and was in place at the time of the elopement on was the GPS bracelet that was issued by the Brevard County Sheriff's department. The function of this GPS bracelet is to locate a resident when they go missing. There were no supervision interventions or approaches in place to prevent a resident, who was an elopement risk, from eloping again. Class II	A 025		
A 032 SS=D	59A-36.007(8) FAC Resident Care - Elopement Standards	A 032		

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A 032	Continued From page 6 59A-36.007 (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 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response	A 032		

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A 032	Continued From page 7 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. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that at risk residents had required identification on their persons that included the resident's name, the facility's name, address, and telephone number for 1 of 3 sampled residents (#1). Findings: Observation of resident #1 on [redacted] at 10:35AM found him dressed and returning from the shower. He did not have any identification on his person. Resident #1's record revealed an admission date	A 032		

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A 032	Continued From page 8 of . . . . . . His health assessment was dated and noted diagnoses including damage due to ,, . . . and . . . . He was assessed to be independent with most Activities of Daily Living (ALDLs) except that he needed supervision with ,, grooming and eating. He was documented to be at risk for elopement. There was a photograph in his record. Notes reflected that resident #1 eloped from the facility in and again on . (photographic evidence obtained) On . . . . . at 1:30 PM, the administrator confirmed resident #1 was not provided with identification with his name and the name, address and phone number of the facility. She said he was wearing a GPS ankle bracelet provided by the county sheriff's office, but it did not have the resident's name on it or information about the facility. The administrator stated she did not know ID was required. Class III	A 032		