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
	AL11968716	A. BUILDING: _____ B. WING _____	07/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM BAY MEMORY CARE	350 MALABAR RD SW PALM BAY, FL 32907

(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 #2020012221 was conducted on [redacted]. Palm Bay Memory Care had a deficiency found 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		

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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 review and interview, the facility failed to maintain a general awareness of the safety and well-being for 1 out of 6 residents (#1). Findings: Resident#1's medical history revealed , and , Type . The resident was independent with daily living and was not an elopement risk. The Medication Records Log reflected the resident was prescribed , 25 milligrams. (mg.) 2 times per day. "...is an ... drug prescribed to treat , and ..." (medicinenet.com). The facility's incident report for resident #1, dated , reflected that the resident was not seen since lunch time. At approximately 3 p.m., a staff person saw the resident walking down the road from the facility, while she was on her way to work at the facility. When the staff member got to the facility she searched resident#1's room and noticed the window screen was bent and the	A 025		

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A 025	Continued From page 2 window lock was preyed off. The police were then called. Law enforcement and staff went out to locate the resident and found him 3 miles away from the facility in a shopping center. He was then brought to the facility approximately at 4 p.m.. He was found to have no injuries. The Law enforcement's report, dated , reflected that they were called at 3:48 p.m. to inform them that resident #1 eloped from the facility. It indictaed that a search was conducted around the perimeter area and he was then found at 4 p.m. at a shopping center by law enforcement and staff, approximately 3 miles from the facility, unharmed. The facility's pictures of the incident on showed resident #1's bedroom window with the the screen completely off and the lock on the window preyed open. It showed that resident #1's bedroom window faces an open area of the facility grounds with no security. On at 11 a.m., the Wellness Director revealed resident #1 was last seen on at lunch time, approximately 12 p.m. She stated the staff was unaware he eloped from the facility until 3 p.m. that day, when a staff member coming into work thought she saw someone that looked like him walking down the road. She stated the resident's room was checked and staff noticed the screen was bent and the lock on the window was broken off. She stated they then searched the facility inside and outside the property. She stated Law Enforcement was then called. She stated the resident was found by staff and law enforcement at a shopping center down the road unharmed. She confirmed the facility policy is to have a general awareness of resident safety and to have "eyeballs" on all residents	A 025		

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A 025	Continued From page 3 every 1 to 2 hours per day and they were unaware of resident#1's whereabouts at the time of the incident. On . . . . . at 10 a.m., tesident#1's guardian confirmed she was informed on that resident #1 had eloped from the facility by using a utensil from the lunchroom to pry open a lock on resident #1's bedroom window and that he was unharmed. She stated the facility informed her that he was found at a shopping center 3 miles away from the facility. She also confirmed that at the time of admission for resident #1, staff would keep an , on the resident's whereabouts every 1 to 2 hours per day. She stated she "could not understand how something like this could happen in a secure facility and that the facility put [resident #1] at risk." On at 12 p.m., the administrator stated the staff now keeps "eyeballs on [resident #1] every 15 minutes and he was moved to an interior room that faces the secure courtyard. The administrator also confirmed all above findings. Class II	A 025		