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
	AL11911234	A. BUILDING: _____ B. WING _____	01/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA ON TURKEY CREEK	2800 FORDHAM ROAD, NE PALM BAY, FL 32905

(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 #2020016547 and control assessment was conducted at Bethesda on Turkey Creek Assisted Living Facility on . A deficiency was found at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall 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 must notify the resident ' s representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for 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	A 025		

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A 025	Continued From page 1 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 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 written internal incident report, and the facility failed to have any written facility's notes for 2 of 3 sampled residents (#2 & #3) as required for an incident that occurred. Findings: On . . . . . at 2:45 PM, an incident occurred with resident #2 and resident #3, both were Assisted Living residents that attempted to leave the facility without signing out at the front desk and letting the facility know. Both residents were found a few minutes later, outside on the property	A 025		

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A 025	Continued From page 2 when staff A was leaving off work. There was no written documentation from all witness staff about this incident found written in the facility's notes and no internal written incident report completed by the Administrator was found. (Photographic evidence obtained) Resident #2's record review revealed admission date . The 1823 Health Assessment dated documented that she is alert and oriented, not an elopement risk. She is independent with all activities of daily living (ADLs). Resident #3's record review revealed admission date . The 1823 Health Assessment dated documented that he is alert and oriented, not an elopement risk. He is independent with all activities of daily living (ADLs), except for assistance with ambulation. He ambulates via wheelchair. On at 2:19 PM, an interview with the Resident Care Coordinator stated that she was a witness to resident #2 and resident #3 attempting to leave the facility without properly signing out and letting staff know. On at 3:50 PM, an interview with resident #2. She stated that she was just trying to go with her friend and resident #3 to the store, her sister's house in Virginia and with resident 3's mother's house in Melbourne. She stated that this was first time ever leaving. She stated that she told the Administrator but forgot to sign out at the front desk. On at 4 PM, interview with resident #3 regarding to leaving with resident #2 on	A 025		

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A 025	Continued From page 3 . . . . . He said they just wanted to go visit their family members. That was all. They were coming . . . He said that they did not even get far at all, just up to the stop sign on the property right outside. He understood now that he must sign out at the front desk. He stated that next time he will let staff know where he was going. On . . . . . at 5 PM, during exit interview with the Administrator acknowledged he knew resident #2 and #3 was leaving the facility on . . . . . but did not write any documentation about the incident and confirmed the findings. Class III	A 025		