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
	AL11953542	A. BUILDING: _____ B. WING _____	03/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMS OF LONGWOOD (THE)	480 EAST CHURCH AVENUE LONGWOOD, FL 32750

(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 #2021002275 and [redacted] Control Assessment were conducted on [redacted]. The Palms of Longwood had a deficiency 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 shall 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 must notify the resident ' s representative or designee of the need for health care services and must assist in making [redacted] 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 resident diets in accordance with rule	A 025		

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A 025	Continued From page 1 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 facility documentation, resident record review and interview, the facility failed to provide appropriate supervision to prevent elopement for 1 of 1 sampled residents (#1) in a secured Memory Care unit. Findings: Facility notes dated on at 7 PM revealed resident #1 eloped from the upstairs secured Memory Care unit out of the exit door that was left cracked open by staff C. Resident #1's record review revealed an admission date of . The 1823 Health	A 025		

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A 025	Continued From page 2	A 025		

Assessment form, dated , identified resident #1 as an elopement risk, and had medical diagnoses of and 's . He required assistance with all activities of daily living (ADLs). He was awake but disoriented and only followed followed simple instructions. Photographic Evidence Obtained.

On at 1:50 PM, staff A stated that on at approximately 6 PM, she received a phone call from caregiver staff B upstairs stating that he saw outside the window from upstairs in the Memory Care secured unit that resident #1 was outside, getting ready to jump the fence. Staff A said she immediately went outside to check the surrounding area but resident #1 had already disappeared. Staff A proceeded to jog a up, southbound on Church Street and asked neighbors outside if they had seen resident #1. Staff A did not see him, so she decided to jog west to the convenience store on Road 434, about 2 blocks away. Staff A said she saw resident #1 standing under the light and went up to him gently and grabbed his . Staff A stated that the store manager called the police and ambulance. The first responders came, examined resident #1, and did not find any harm or injury to the resident. The police drove resident #1 and staff B to the facility, and staff A jogged to the facility. Staff A stated the total amount of time was about 20 minutes maximum from when resident #1 eloped from the facility and he was found.

On at 2:05 PM, a telephone interview was conducted with staff B about the elopement incident involving resident #1 on . Staff B stated that he was upstairs in another resident's room, happened to look out the window, and saw outside of the Memory Care unit downstairs that

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A 025	Continued From page 3 resident #1 was getting ready to jump the fence. Staff B stated he immediately called the front desk receptionist, staff A, to see if she could stop and catch him. Staff B called for backup staff to secure the memory care unit and joined and staff A to help locate resident #1. Staff B stated that he noticed the exit door was cracked open and the alarm was off to the outside stairway. Staff B closed and secured the door. Staff A and staff B collaboratively found resident #1 at the convenience store located on a major road, State Road 434, about 2 blocks away from the facility. Staff B notified the Director of Nursing (DON) and Administrator of the incident. The facility's Adverse Incident Report #543365 to the Agency for Health Care Administration, dated , revealed the elopement incident on reported by the Administrator. The Administrator confirmed that an internal investigation revealed that resident #1 eloped from the Memory Care unit upstairs by the exit door being cracked open by staff C. The Administrator determined that staff C did not follow the facility's elopement policies and procedures of always keeping all exit doors locked and alarmed, never being left unlocked unless it is a fire emergency which are designated, especially important in the Memory Care unit. She confirmed that staff failed to supervise all residents, especially in the Memory Care unit. Photographic Evidence obtained. On at 3 PM, an interview with the DON confirmed and agreed with the findings. Class II	A 025		