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
	AL11911132	A. BUILDING: _____ B. WING _____	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEAN VIEW MANOR	624 S ATLANTIC AVENUE DAYTONA BEACH, FL 32118

(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 Change of Ownership survey with Limited Mental Health monitoring was conducted at Ocean View Manor on . Deficiencies were identified at the time of survey.	A 000		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or	A 165		

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A 165	Continued From page 1 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency ' s online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency ' s online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident. (6) . . . . , neglect, or . , ... must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct	A 165		

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A 165	Continued From page 2 by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on interviews with staff and a review of resident and facility records, the facility failed to file an adverse incident report following a resident elopement for 1 of 1 residents revived for	A 165		

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A 165	Continued From page 3 elopement (Resident 11), and out of a total of 12 residents in the sample. The findings include: Employee D, Medication Technician, was interviewed on . . . . . at 10:50 am. When asked if any resident had ever from the facility, she said yes, Resident 11 did a few months ago. His mother gives him money and he saved it up and got on the bus to Deland (approximately 26 miles away). Staff try to keep . . on him. Resident 11 came . . . the next day. His mother knows where he goes and found him at the Deland Walmart. There is a sign out process for when residents leave the building, but he doesn't sign out. He walks a lot and just off. He doesn't do it often Employee E, Medication Technician, was interviewed on . . . . at 11:50 am. She reported that one time when she first started working here, Resident 11 . . . . . from the facility. Employee F, Medication Technician and Activities staff, was interviewed on at 1:48 pm. She too stated Resident 11 . . . . . off and ends up elsewhere. The last time he did, about a month ago, he got on the bus to Deland. Record review for Resident 11 found he was admitted to the facility on . . The ACHA Resident Health Assessment, form 1823, dated noted diagnoses including acute . . . . . and . . . . . . The medical examiner noted Resident 11's . . status was within normal limits to person, place and time. He was independent with	A 165		

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A 165	Continued From page 4 activities of daily living and required assistance with medication administration set-up. The examiner noted on the form that Resident 11 was at risk for elopement. Photographic evidence was obtained. An Elopement Risk Assessment dated noted in case of an elopement look for Resident 11 at the Daytona Beach or Sanford Walmart stores or his previous assisted living facility in Sanford. Resident has history and does not say he wants to leave. He was assessed as being at high risk. Photographic evidence was obtained. A review of , Subsequent Note dated reports Resident 11 ran away and his mother brought him . He has a history of running away about every 6 months, but since medication changes in he has been running away times per month. Resident reported he took a bus to Orlando. Photographic evidence obtained. Review of the referenced police department receipt found a police report (#DB210009608) was filed on at 0015 (12:15 am) for a missing person. A report was made but the copy of the report was not in the facility for review. Photographic evidence was obtained. Review of facility records found no adverse incident report was filed with the State Agency for Resident 11's elopement. Review of the facility Elopement Policy dated found it stated the facility Administrator is responsible for the compliance with the terms and conditions of the Florida State mandated elopement policy. Under the section "Resident Elopement Prevention Drill/Response	A 165		

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A 165	Continued From page 5 Procedures" note that following an occurrence, the responsible party will file a 1 day adverse incident report with the State Agency. An interview was conducted with the Administrator on at 2:26 pm. She explained Resident 11's mother was very active in his life. They know what he is going to do and where he is going but he just doesn't sign out. Sometimes Resident 11 is gone 24 hours. He sold his cell phone so he no longer has one. Resident 11 ran away on the 24 of . He had gone to a sandwich shop to get a free meal. That was when the police report was filed. He was found in Deland a long time ago after he first was admitted. There have only been those two elopements since admission. The Administrator admitted she did not file an adverse incident report, explaining she didn't know if she should have. She acknowledged the requirement. Class III	A 165		

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