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
	AL11969003	A. BUILDING: _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRILL GARDENS AT SOLVITA MARKETPLACE	4600 MARIGOLD AVE KISSIMMEE, FL 34758

(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 #2022007615 and Generator Monitoring was conducted on . Merrill Gardens at Solivita Marketplace had a deficiency at the time of survey.	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 ... 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 Resident Care Standards. 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 observations, interviews and record reviews, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision to 1 of 3 sampled residents who eloped from the secured memory care unit of the facility (#1). Findings: Resident #1's record revealed she was admitted on into the memory care unit. An 1823 Resident Health Assessment, dated , indicated resident #1 was not an elopement risk,	A 025		

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A 025	Continued From page 2 and her needs can be met in an assisted living facility. The 1823 indicated she was forgetful and at risk for . . . An undated 1823 (, ... version of form) was also in resident's file which indicated resident was not an elopement risk. A service plan, dated , indicated the resident was a risk and an elopement risk. A facility note indicated resident #1 eloped from the facility on .. . . . . A facility note, written on at 12:02 PM and signed by the Director of Nursing (DON), indicated resident #1 was found by the Sheriff's Department in the . . . of the community on .. . . at 9:15 PM. A facility note, written on at 2:38 PM, indicated there was frequent monitoring of resident #1 in place. There was no other documentation related to resident #1's elopement or increased monitoring. The resident was missing from the secured memory care unit for approximately twenty-five (25) minutes without staff knowledge. On . . . . at 1:40 PM, the DON confirmed resident #1 eloped from the locked memory care unit. The DON said she assumed resident #1 exited the memory care unit through the main door that was not properly secured. DON said she thought resident #1 then exited the building through the automatic doors to the parking lot. She said there was no other way resident #1 could have exited the memory care unit. She said resident #1 was not witnessed leaving the facility. The DON said on .. .. at about 9:15 PM, she received a call from staff A notifying her resident #1 got out of the facility and the police found her. She said she went to the facility and when she arrived, two officers and staff A were escorting resident #1 into the facility. The DON said she evaluated resident #1 and she did not have any injuries. She said resident #1 was	A 025		

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A 025	Continued From page 3 placed on hourly checks and her room door was left open so staff could see her when they passed by. She said she spoke to staff about making sure the main door was properly closed and she placed a sign on the door as a reminder to check that door closed securely. The DON said she did not know if the maintenance director was aware of the door not closing and locking properly prior to resident #1's elopement. On [redacted] at 3:45 PM, the DON confirmed the 1823 Resident Health Assessment form for resident #1 was not filled out properly. She said resident #1 was an elopement risk. At 5:40 PM, the DON confirmed there was no documentation of increased supervision and hourly checks for resident #1. On [redacted] at 1:50 PM, an observation of the memory care units main entrance door revealed a sign was taped to it that advised to ensure door was shut properly when entering or exiting. Observation of the doors and alarm revealed the alarm did function when the door opened, and the door locked when closed. On [redacted] at 4:15 PM, staff B said she was working 3 PM-11 PM in memory care on [redacted] when resident #1 eloped. Staff B said resident #1 [redacted] around the unit all the time and would try to push the exit doors. Staff B said she was on break when resident #1 exited the unit. She said she left for break at about 8:50 PM. She said she saw resident #1 in the memory care unit when she left for her break. Staff B said staff A called her [redacted] to the memory care unit because the Sheriff's office called and said resident #1 was out of the building. She said the DON came in to monitor resident #1, and she was fine. She said after resident #1 returned, they	A 025		

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A 025	Continued From page 4	A 025		

checked on her more often; they left her room door open; they checked all the windows and doors. Staff B said she was aware the main door sometimes did not close all the way, so she made sure the door was locked when she left. She said the Maintenance Director fixed it after resident #1 eloped.

On . . . . . at 4:30 PM, staff A said she was working as the medication technician (med tech) on the memory care unit when resident #1 eloped on . She said she went on break at about 9 PM and returned to the unit at about 9:15 PM. She said while finishing the medication pass, she received a call from the police. The police informed her they had found resident #1 . . . . . down the road. She said she called the DON and then left the unit to go get resident #1. She said the officer brought resident #1 . . . to the facility in his car. Staff A said the DON came in and checked resident #1. Staff A said she believed resident #1 exited through the main door because it did not always close all the way.

On . . . . . at 4:40 PM, staff C said she was working in the memory care unit on when resident #1 exited the building. She said she found out about resident #1 being outside when staff A notified her the police had called. She said resident #1 was a high risk because she often pushed the doors. She said when resident #1 returned, she was checked by the DON and then she went to bed. Staff C said she thinks resident #1 went out the main memory care door because it did not always close all the way.

On . . . . . at 4:45 PM, the Administrator and Maintenance Director confirmed the main door to the memory care unit was adjusted after the elopement of resident #1 on , so it

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A 025	Continued From page 5 closed securely even when courtyard door was open. The Maintenance Director said he was not aware the memory care door was not working properly prior to resident #1 elopement. The facility's Elopement policy, revised on [redacted], indicated the definition of elopement was a [redacted] resident who should not leave the community unsupervised according to their service plan. A resident who leaves the community or secured area without supervision or the knowledge of staff. Class II	A 025		