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
	AL11967480	A. BUILDING: _____ B. WING _____	R 06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A PLACE LIKE HOME ALF, INC	1971 PORT MALABAR BLVD 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 revisit to a re-licensure survey was conducted on [redacted] at A Place Like Home Assisted Living Facility. One deficiency remained uncorrected at the time of the 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 [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 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 resident diets in accordance with Rule	{A 025}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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: DEFICIENCY REMAINED UNCORRECTED Based on 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 to1 of 1 sampled resident who eloped from the facility (#3). Findings: On a review of resident #3 record revealed he was admitted on . His record contained a Resident Health Assessment form	{A 025}		

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{A 025}	Continued From page 2 (1823) dated . . . . . His diagnoses included unsteady gait, , , and . The resident was independent with all activities of daily living except bathing for which he required supervision. His physical limitations included an unsteady and shuffling gait. Review of a facility note dated (no time indicated) revealed resident climbed over the yard fence. Police were called. He was brought . . . safely. (Noted during previous survey conducted) There were no facility notes provided after request for the elopement incident on . The Facility did timely submit an Adverse Incident Report which included a description and timeline of the event. A review of an incident Report dated . . . . . revealed resident #3 had been weak and barely able to walk from his room for weeks. He shuffled when he walked and sometimes bumped into walls. He was not considered a flight risk as his physical capacity had declined. Around 10:10am on . . . . . resident #3 left the facility through the door and went out through an unlocked side gate. Staff A was busy letting a visitor in the front door. Staff A could not leave the facility because she was the only staff onsite. She called the administrator. At approximately 10:15am staff B arrived, and Staff A went by car to look for resident #3. The administrator also started driving around and she called the police. Resident #3 was found several blocks away after a concerned citizen contacted the police department. He was taken to the Hospital for evaluation then returned to the facility the same day. The incident lasted around 2 hours. No time was documented when the resident was found.	{A 025}		

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{A 025}	Continued From page 3 A review of a police report dated at 9:29am revealed, on resident #3 escaped from the assisted living facility and was missing. Resident #3 was deemed , . He was located after an extensive search using K-9, BCSOAg-Marine unit, and Aviation Unit. Resident #3 was recovered from the woods inside Turkey Creek Sanctuary. No specific time resident #3 was found was documented. (Google map - 1mile from facility) On at 4:20pm in an interview with the administrator, she confirmed resident #3 eloped from the facility again on at approximately 10:10am because staff A did not check the lock on the gate. She said she ordered an identification bracelet, after the last survey, but resident #3 was not wearing it on when he eloped. The bracelet was ordered around , , and it had not been delivered until . She confirmed resident #3 did not have proper identification on his person when he eloped on . She confirmed his 1823 had not been updated to include elopement risk after he eloped on . A review of an undated facility elopement policy provided by the administrator revealed the protocol to be followed when a resident is missing which included: Alert all staff of missing resident, search facility, call 911, notify family, document disappearance in resident record. The policy did not include information related to identifying residents at risk for elopement. On at 4:25pm the finding was confirmed by the administrator.	{A 025}		

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{A 025}	Continued From page 4 Class II	{A 025}		