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
	AL11963814	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BV ASSISTED LIVING INC.	2127 W. NEW HAVEN AVENUE WEST MELBOURNE, FL 32904

(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 #2022018726 was conducted at BV Assisted Living Facility on . A deficiency was identified 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 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 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: Based on observation, interview, and record review the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision for 2 of 5 sampled residents. Resident (#1) who sustained a with injury and resident (#2) who eloped from the facility. Findings: 1. On a review of resident #1 record revealed she was admitted on . Her record contained a Resident Health Assessment form (1823) dated . Her diagnoses included , , , , and ,	A 025		

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A 025	Continued From page 2 . She required assistance with bathing. She was independent with all other activities of daily living. A review of an Adverse Incident Report for resident #1 revealed on at approximately 1:45pm resident #1 was on her mobility scooter when the facility transportation van turned a corner the scooter tipped over and the resident to the van floor. At around 3pm the resident complained of and an r-ray was ordered. The was not completed by 5pm so her son took her to the emergency room. She was admitted to the hospital with 4 . A review of the facility incident report revealed on at 1pm resident #1 was transported on her scooter. When the van turned a corner, the scooter tipped over. Resident had right side under arm. A review of the facility transportation policy dated under power wheeled devices it was documented: The transport of power wheeled devices is permitted on the lift van when equipped with the leasing and insurance companies required "tie down" safety device. On at 12:55pm an interview with the administrator was conducted. She said resident #1 did have the correct tie down on her scooter but she could not say whether the driver tied her chair down correctly since it tipped over. Resident #1 was not seat belted onto the scooter. She confirmed the driver picked her up off the floor of the van and brought her to the facility. After she returned, she complained of and her son took her to the emergency room.	A 025		

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A 025	Continued From page 3 2. On [redacted] a review of resident #2 record revealed he lived in the secure memory care unit. His record contained an 1823 dated [redacted]. His diagnoses included [redacted] valve [redacted], agitation, and [redacted]. The 1823 documented poor safety awareness and elopement risk. Independent with eating, grooming, and transfer. Supervision required with ambulation, bathing, [redacted], and toileting. A review of the facility notes revealed: On [redacted] resident moved to the memory care unit at 12:30pm. On [redacted] at 12:41pm resident continues to exit seek. On [redacted] at 11:09am resident continues to exit seek On [redacted] at 8:48pm resident was seen walking in front of the memory care building towards the main building. On [redacted] at 9:27am after breakfast staff found resident trying to exit through the torn screen on his patio. Staff was able to bring him inside. Waiting on locksmith. A review of the administrator notes revealed: On [redacted] at 11am The Executive Director followed the resident out the door again. He's getting worse with increased paranoia, agitation, and roaming. [redacted] at 3:43pm Spoke with son regarding elopement incident on [redacted]. At some point resident took a screwdriver from the maintenance cart and used it to unscrew the lock on the door leading out to his patio, cut the screen, and to get out the gate. On [redacted] at 10:15am an interview was	A 025		

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A 025	Continued From page 4 conducted with resident #2. He was observed in the memory care unit common area. He said he did not have identification. He did not know where his identification was. He was not observed wearing an ID bracelet. He said he often goes for walks and can do so whenever he wants. 10:20am an interview with med tech A was conducted. She said she checks identification (ID) arm every shift. After checking she documents her check on the Medication Observation Record (MOR). She said there were 4 residents in the memory care unit who were at risk for elopement. None were observed wearing ID . . . . . Staff A confirmed the finding and said they take them off and then the staff can't find them. Review of the MOR revealed the ID check was signed every shift, but it did not indicate if ID was on the person only that they were checked. A review of the facility Elopement Policy revealed: Elopement is the ability of a resident to successfully leave the facility unsupervised and unnoticed who may enter into harm's way. On . . . . . at 2:45pm the administrator confirmed resident #2 was able to elope from the memory care unit by taking a screwdriver from the maintenance cart and removing the lock on the door leading out to his screened porch. He then cut the screen and climbed out through the hole. He then used the screwdriver to break the lock on the gait leading to the parking lot. Class II	A 025		