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
	AL11910710	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRIMENT ASSISTED LIVING RESIDENCE	1835 WILSON STREET HOLLYWOOD, FL 33020

(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 An unannounced Complaint survey (#2023012716 and #2023015525) was conducted on through at Merriment Assisted Living Residence. The facility had deficiencies identified related to Complaint #2023012716 and #2023015525 at the time of the survey.	A 000		
A 025	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,	A 025		

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A 025	Continued From page 1 including the following: (a) Monitoring of the quantity and quality of 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 observation, interview, record review and the facility's elopement policy review, the facility failed to ensure that 4 of 4 sampled residents (Resident #1, Resident #2, Resident #3, and Resident #4) were closely monitored to prevent elopement and adverse incident. The findings included: Review of the facility's Elopement Policy documented that any resident who leaves the facility's premises without signing out and	A 025		

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A 025	Continued From page 2 notifying staff is considered to have eloped. 1) Review of a facility report dated . . . . . revealed that on the aforementioned date, between 7:00 PM and 8:00 PM, Resident #1 eloped from the facility. After searching for Resident #1 to no avail, a missing person alert was filed, and the Administrator contacted the police at 11:00 PM. The police found Resident #1 on and brought him to the facility at 1:30 AM. Resident #1 was diagnosed with Bi-Polar , history of Conversion , , ... , and , , ... The Resident Health Assessment record, (AHCA form 1823) dated revealed that Resident #1 was at risk for elopement. However, subsequent 1823 forms dated . . . . . , ... , and identified Resident #1 as not being at risk for elopement. Assistant Administrator Employee A said on at 10:00 AM, that Resident #1 was not compliant with following the facility's Sign In/Out Log process. He signs out sometimes, but not in. The Sign In/Out Log documented when residents are in and out of the facility. Meanwhile, the facility took no corrective measures to remediate the situation. The Administrator said on at 10:50 AM, that Resident #1 had for the most part followed the Sign In/Out process. She said that they need to improve the process by ensuring that everyone signs the book when they are leaving the facility. Review of the Sign In/Out Log documented that Resident #1 signed out:	A 025		

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A 025	Continued From page 3 on [redacted] at 10:20 AM and did not sign [redacted] in. on [redacted] at 8:30 AM and signed [redacted] in at 1:30 PM (first documented elopement) on [redacted] at 12:30 PM and he did not sign [redacted] in. on [redacted] at 9:00 AM, he did not sign in. on [redacted] at 10:00 AM, he did not sign in. on [redacted] at 6:00 PM, he did not sign in. on [redacted] at 5:30 PM, he did not sign in. on [redacted] at 5:30 PM, he did not sign in. on [redacted] at 5:30 PM, he did not return, he committed [redacted] at an offsite location. 2) Resident #2 was admitted to the facility on [redacted] with the following diagnoses: [redacted]; and [redacted]. Resident #2 was determined to be at risk for elopement as documented in the Resident Health Assessment form 1823 dated [redacted] and [redacted]. An Elopement Drill dated [redacted], showed that Resident #2 had eloped from the facility. The Elopement Report revealed that Resident #2 left the facility after taking her medication at 5:30 PM. The Elopement Drill was activated at 7:30 PM and it ended at 7:41 PM, after the police brought the resident [redacted] to the facility. Review of a resident evaluation showed that on [redacted] the resident [redacted] off the property and could not find her way [redacted]. There was no Adverse Incident report filed. 3) Resident #3, was admitted to the facility on [redacted], and left the facility on [redacted] a	A 025		

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A 025	Continued From page 4	A 025		

few days after his admission. No one knew how, the exact time (when) he left the facility. Review of the Elopement Report Drill and the facility Report documented that Resident #3 was last seen by his roommate at 10:00 AM. However, staff documented that Resident #3 was not seen during breakfast, which is customarily scheduled for 8:00 AM. Resident #3 did not sign out before leaving the facility. The facility Report revealed that the facility informed Resident #3's sister that he was missing at 4:00 PM on . The facility notified the police at 8:48 PM, the same day. On , after five days away from the facility, Resident #3 contacted his sister to inform her of his whereabouts, and staff from the facility met with Resident #3 and brought him to the facility. No Adverse Incident Report was filed.

Review of the Resident Health Assessment form 1823 dated documented that Resident #3 was diagnosed with disorganized , . He required medical management and supervision. Resident #3 had no physical limitation. The 1823 documented that Resident #3 was at risk for elopement, but redated. After the first elopement, a new 1823 was completed and documented that Resident #3 is at risk for elopement.

4) Review of a facility report dated documented that Resident #4 left the facility on at around 10:00 PM without notifying facility staff or signing out. The Administrator was notified that Resident #4 went missing on at 7:48 AM. The facility contacted the police on at 7:30 PM to file a missing person report. On , the Administrator documented that Resident #4 returned to the facility on his own (no time indicated). When questioned, Resident #4 replied that he went out

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A 025	Continued From page 5 to walk and could not remember how to get . . . to the facility. Resident #4 spent the entire night out of the facility. However, the facility never reported the incident to the Agency for Health Care Administration via an Adverse Incident Report. Observation of the Sign In/Out Log review conducted on . . . . . at 3:30 PM, revealed that residents left the property without signing the logbook and without informing any staff members. The concern was discussed with Employee A who stated that they are monitoring the residents on camera. However, Employee A did not see or know that one of the residents had left the facility without informing anyone or signing out. Observation conducted throughout the facility on and revealed a non-gated community with multiple exit points on the Northside, Eastside, Southside, and Southwest side of the premises. Although there are video cameras throughout the property, they are sparsely monitored. Consequently, residents at risk for elopement can exit the property at will. Furthermore, a review of the staffing schedules revealed that there usually are only two employees on duty during the third shift (11:00 PM to 7:00 AM). With all these exit points, lack of manpower to supervise 47 residents currently residing in the facility during the third shift, and no one monitoring the cameras, there is a high likelihood that residents with intent to elope can do so without being noticed. Class III	A 025		

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A 165	Continued From page 6	A 165		
A 165	429.23(&) FS Risk Mgmt & QA 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 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	A 165		

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A 165	Continued From page 7	A 165		

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 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

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A 165	Continued From page 8 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. This Statute or Rule is not met as evidenced by: Based on observation, interview, record review, and the facility's Elopement Policy review, the facility failed to file Adverse Incident Reports in cases involving 4 of 4 sampled residents reviewed for elopement (Resident #1, Resident #2, Resident #3, and Resident #4). The findings included: Review of the Facility's Elopement Policy documented that any resident who leaves the facility's premises without signing out and notifying staff is considered to have eloped. 1) Review of a facility report dated revealed that on the aforementioned date, between 7:00 PM and 8:00 PM, Resident #1 eloped from the facility. After searching for Resident #1 to no avail, a missing person alert was filed, and the Administrator contacted the police at 11:00 PM. The police found Resident #1 on . . . . . and brought him . . . to the facility at 1:30 AM. Resident #1 was diagnosed with Bi-Polar	A 165		

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A 165	Continued From page 9 , History of Conversion , , and , , , . The Resident Health Assessment record, (AHCA form 1823) dated revealed that Resident #1 was at risk for elopement. However, subsequent 1823 forms dated , , and identified Resident #1 as not being at risk for elopement. Assistant Administrator Employee A said on at 10:00 AM, that Resident #1 was not compliant with following the facility's Sign In/Out Log process. He signs out sometimes, but not in. The Sign In/Out Log documented when residents are in and out of the facility. The Administrator said on at 10:50 AM, that Resident #1 had for the most part followed the signing process. She said that they need to improve the process by ensuring that everyone signs the book when they are leaving the facility. 2) Resident #2 was admitted to the facility on with the following diagnoses: , , ; , , ; , ; and . Resident #2 was determined to be at risk for elopement as documented in the Resident Health Assessment form 1823 dated and . An Elopement Drill dated , showed that Resident #2 had eloped from the facility. The Elopement Report revealed that Resident #2 left the facility after taking her medication at 5:30 PM. The Elopement Drill was activated at 7:30 PM and it ended at 7:41 PM, after the police brought the resident to the facility. Review of a resident evaluation showed that on the resident off the	A 165		

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A 165	Continued From page 10 property and could not find her way . . . . There was no Adverse Incident Report filed. 3) Resident #3 was admitted to the facility on . . . . . , and left the facility on . . . a few days after his admission. No one knew how, the exact time (when) he left the facility. Review of the Elopement Report Drill and the facility report documented that Resident #3 was last seen by his roommate at 10:00 AM. However, staff documented that Resident #3 was not seen during breakfast, which is customarily scheduled for 8:00 AM. Resident #3 did not sign out before leaving the facility. The facility report revealed that the facility informed Resident #3's sister that he was missing at 4:00 PM on . The facility notified the police at 8:48 PM, the same day. On , after five days away from the facility, Resident #3 contacted his sister to inform her of his whereabouts, and staff from the facility met with Resident #3 and brought him . . . . to the facility. No Adverse Incident Report was filed. Review of the Resident Health Assessment form 1823 dated . . . . . documented that Resident #3 was diagnosed with disorganized . . . . . , ... He required medical management and supervision. Resident #3 had no physical limitation. The 1823 documented that Resident #3 was at risk for elopement, but redated. After the first elopement, a new 1823 was completed and documented that Resident #3 is at risk for elopement. 4) Review of a facility report dated . . . . . documented that Resident #4 left the facility on . . . . . at around 10:00 PM without notifying facility staff or signing out. The Administrator was notified that Resident #4 went missing on at 7:48 AM. The facility contacted the	A 165		

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A 165	Continued From page 11 police on . . . . . at 7:30 PM to file a missing person report. On , the Administrator documented that Resident #4 returned to the facility on his own (no time indicated). When questioned, Resident #4 replied that he went out to walk and could not remember how to get to the facility. Resident #4 spent the entire night out of the facility. However, the facility never reported the incident to the Agency for Health Care Administration or filed an Adverse Incident Report. The Administrator said on . . . . . at 11:20 AM that she did not know that she was supposed to file an Adverse Incident Report when residents went missing. She said that they have since implemented a monitoring process to supervise residents at risk for elopement, they monitor them every thirty minutes and every hour. Observation of the Sign In/Out Log review conducted on at 3:30 PM, revealed that residents left the property without signing the log book and without informing any staff member. The concern was discussed with Employee A who stated that they are monitoring the residents on camera. However, Employee A did not see when one of the residents left the facility unannounced. Class III	A 165		