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
	AL11964559	A. BUILDING: _____ B. WING _____	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARIS POINTE	1200 AVENIDA DEL CIRCO VENICE, FL 34285

(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 for #2022016528 and #2023008450 was conducted on at Maris Pointe, an assisted living facility in Venice, Florida. Complaint #2022016528 was substantiated at A 023. Complaint #2023008450 was substantiated at A 023. The following is a description of the deficiency.	A 000		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained	A 032		

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A 032	Continued From page 1 pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record reviewed and staff interview facility failed to implement elopement policy and	A 032		

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A 032	Continued From page 2 procedure in response to elopements related to 2 (Resident #2 and # 8) out of 2 residents reviewed for elopements. Findings included: Requested and received policies titled: Safety Checks. Policy stated the following: "6) Routine safety checks are made by staff to account for residents whereabouts. A check is made once each hour during shift and at each change of shift." Elopement/missing person. Policy stated the following: "Staff will respond immediately with emergency procedures when a resident has been identified as missing. 2: The executive director and director of memory care are immediately notified. 6. All search staff call or report within 10 minutes to provide current status." Record review for Resident #2 showed he was admitted to the facility on . The Resident Health Assessment (HA) dated , indicated a diagnosis of . Resident was not identified as an elopement risk per HA on record. Further review for Resident #2 showed that resident eloped from the facility on and again on . Review of the investigation report for the second elopement that took place on revealed that Staff A called the facility's Director of Health and Wellness (DHW) on to inform her that Resident #2 was missing. The report documents the DHW asked Staff A when the last time was they saw Resident #2. Staff A responded, "We didn't see him all night. We don't do checks on him because he gets mad and starts packing his things."	A 032		

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A 032	Continued From page 3 In an interview on at 1:00 p.m., the DHW confirmed that Staff A told her that they did not do the hourly monitor for Resident #2 as they should. DHW said she was very upset that Staff A did not follow the facility's policy and wrote up Staff A for not doing what is expected. No documentation disciplinary notation for Staff A was provided. DHW said they had multiple meetings with all staff to ensure they are following facility's policy and check on residents hourly. DHW said that the expectation was that staff check all residents hourly, notify her immediately if a resident was missing, and complete their search for the resident within 15 minutes. Record review for Resident #8 showed he was admitted to the facility on . Review of the HA (dated . . . . .) for Resident # 8 showed a diagnosis of . and and was not deemed as an elopement risk at the time of admission. Resident #8 eloped from the facility on . . . . at 2:00 a.m. (12 hours after he was admitted the the facility.) The resident exited the facility from the kitchen door that was left unlocked. Review of the investigation report for Resident #8 revealed staff reported that last they saw, Resident #8 was watching television at 12:30 a.m. and did not want to go to sleep. At the 2:00 a.m. check they realized Resident #8 was missing. Staff searched the facility for an hour before they notified the DHW. Staff A called DHW at 3:26 a.m. to notify her that Resident #8 was found by the police and returned to the facility. In an interview on at 1:30 p.m., the DHW confirmed that staff did not follow the facility's procedure by not completing hourly checks on	A 032		

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A 032	Continued From page 4 Resident #8. Furthermore, the staff failed to report the elopement immediately to their supervisor as required. DHW said they had multiple staff education sessions to ensure that all staff were aware that they needed to conduct hourly checks on residents and to notify her or the administrator immediately. She also said they needed to complete their search within 15 minutes. During a telephone interview with Staff A on at 1:40 p.m. he said he knew they needed to check on residents every hour, but he did not recall if they did that the night Resident #2 eloped. In an interview on at 2:10 p.m., Caregiver Staff B said, "We check resident every 2 hours. " On at 2:11 p.m., Staff C said, "Its the standard of practice to check the residents every 2 hours." On at 2:19 p.m., Staff D said, "We make sure to check the residents every 2 hours." On at 2: 23 p.m., Staff E said. "We need to make sure to check them every 2 hours." During an interview on at 3:00 p.m., the Administrator said staff should check on all residents every hour. It is what is expected of them. He said he had multiple in-service training with staff and re-educated them on the importance of frequent checks. Class III	A 032		