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
	AL11968003	A. BUILDING: _____ B. WING _____	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOLANTE OF MELBOURNE	964 S HARBOUR CITY BLVD MELBOURNE, FL 32901

(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 survey for complaint #2024003560 was conducted on [redacted] at Harborside at Melbourne (Volante) Assisted Living Facility. There were deficiencies identified at the time of the survey.	A 000		
A 025 SS=D	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 [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 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, record review, and interview the facility failed to provide care and supervision to meet the needs of 1 of 1 sampled resident (#1) who eloped from the facility and staff were not aware the resident had eloped. Findings: On resident #1 exited the facility unattended. The Director of Nursing (DON) reviewed the camera footage and found resident #1 exited the elevator on the first floor at 9:30pm. She then exited the side door in the lobby. Per the camera footage the resident can be seen turning left to proceed walking South on Nasa	A 025		

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A 025	Continued From page 2 Blvd toward highway US1. She then turns left heading North and out of the camera view. At 3:40am the resident was returned to the facility from the hospital by a non-emergent ambulance. The hospital paperwork indicated she experienced a and had a diagnosis of a ( ). A review of resident #1 record revealed she was admitted on . Her file contained a Resident Health Assessment (1823) dated . Her diagnoses included repeated communication , and . She was independent with ambulation and eating. She required supervision with all other activities of daily living. The 1823 documented she was not an elopement risk. On at 11:25am Resident #1 was observed in a wheelchair in the main lobby of the facility. She was unable to produce any identification. In an interview she was unable to recall leaving the facility unattended on . She said she would never go out at night. She confirmed she had before but was unsure of the dates. At 1:04pm the DON said she did not think resident #1 was at risk for elopement even though she did elope. She felt the resident was no longer at risk after being treated for a . The DON confirmed Resident #1 had no ID on her person. A review of the staff schedule for Sunday found 4 staff scheduled for the 3pm-11am shift in the Assisted Living. It was noted on the schedule that 1 staff (lead tech) left at 9pm which	A 025		

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A 025	Continued From page 3 left 3 staff from 9pm-11pm. There were 2 staff scheduled for the11pm-7am shift. On at 3:30pm an interview with staff D med tech and Staff E med tech was conducted. Both staff confirmed they worked 3pm-11pm on . They said they carry radios to communicate with each other. They can notify each other if there is an emergency or if they need assistance with a resident. When the exit doors open, a message is sent to the radios. Whoever is closest or not busy will go check the door and radio the other staff. They said usually it is the patio door because the residents who smoke go out there. Staff D could not recall if any other door alarm messages were sent on when resident #1 left the facility unattended. On Sunday there were 4 staff but staff E, who was the lead tech, had to leave early because of a family emergency. She left around 9pm. On at 3:10pm The DON confirmed the staff schedule was accurate for . She said staff all carry walkie talkies, and they get a door open message when exterior doors are opened after the receptionist leaves. She confirmed she did not see any staff respond to the door being opened when she reviewed the camera footage after resident #1 left the facility unattended. She said, usually the lead tech was responsible for ensuring the open doors were checked. If she was not available, the other staff were responsible. Class III	A 025		

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A 032	Continued From page 4	A 032		
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 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	A 032		

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A 032	Continued From page 5 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 observations, record reviews, and interviews the facility failed to 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 for 4 of 7 residents sampled. (#4, #5, #6 & #7). The facility failed to ensure staff participated in elopement drills twice annually, pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C. for 1 of 4 staff sampled (F) Findings:	A 032		

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A 032	Continued From page 6 On . . . . at 1:20pm an audit of all resident records with the Director of Nursing (DON) identified 4 residents who were at risk for elopement as documented on their Resident Health Assessment form (1823). All lived in the memory care unit. The DON said the residents do not wear any identification (ID) and there is no daily effort made by staff to check ID. Residents in Memory Care do wear . . . guard bracelets which beep if they leave the memory care unit. The DON confirmed it was not the facility practice for residents to wear or carry ID. 1. A review of resident #4 record revealed he was admitted on . . . . . His Resident Health Assessment dated documented he was at risk for elopement. He was observed in the Memory Care unit with No ID on his person. 2. A review of resident #5 record revealed she was admitted on . . . . . Her Resident Health Assessment dated documented she was at risk for elopement. She was observed in the Memory Care unit with No ID on his person. She was not wearing a . . . guard bracelet. 3. A review of resident #6 record revealed she was admitted on . Her Resident Health Assessment dated . . /2 documented she was at risk for elopement. She was observed in the Memory Care unit with No ID on his person. 4. A review of resident #7 record revealed she was admitted on . Her Resident Health Assessment dated . . . . documented she was at risk for elopement. She was observed in the Memory Care unit with No ID on his person. A review of staff F record revealed she was hired on . Her record contained documentation	A 032		

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A 032	Continued From page 7 of participation in one Elopement Drill on . . . . On . . . . . at 3:40pm the Human Resource Director confirmed staff F only had documentation of participation in one elopement drill in 2023. Class III	A 032		