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
	AL11968390	A. BUILDING: _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERLOX HAVEN LLC	3151 GRANADA BLVD KISSIMMEE, FL 34746

(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 #2024003361 was on conducted [redacted] at Merlox haven LLC Kissimmee. The facility had deficiencies identified at the time of the visit.	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 [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: Based on observations, record reviews and interviews the facility failed to maintain a general awareness of the resident's whereabouts, and maintaining a written record, updated as needed of significant changes for 1 of 1 sampled resident (#1). Findings: The facility had an incident dated related to resident #1 eloped from the facility and was found at the downtown Kissimmee bus station, resident#1's 1823 states that he has a history of . and . There was	A 025		

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A 025	Continued From page 2	A 025		

nothing in the resident's progress notes that stated he was at risk for elopement. The nursing notes did not have anything written about changes in his behavior nor does he display any aggressive tendencies towards staff.

On . . . . at 11:35 am the administrator stated that on the staff called to let her know that resident #1 had eloped from the facility. The administrator stated that when she arrived at the facility, she immediately called 911. Upon the Osceola Sheriff's department arriving at the facility with a K-9 dog, she explained that resident #1 had never eloped from the facility before.

The administrator stated that on at 12:15 pm the dog went into resident #1's room to get the dog familiarized with his scent. The dog then led the sheriff up the street to the bus stop where resident #1's scent went . At that point the sheriff came . . . to the facility to let her know resident # , have gotten on the city bus. The administrator stated that it was during this time that she had called the residents sister who is his POA, to let her know that resident #1 had eloped from the facility. The administrator stated that the sister arrived shortly thereafter.

At 11:47 am the administrator stated that at about 1:20 pm the sheriff's department called and stated that they had found resident #1 downtown at the Kissimmee Bus station and was bringing him . . . to the facility. The administrator stated that when resident #1 arrived at the facility she asked him what it was that made him leave the facility. Resident #1 stated he had someone to see and some stuff to do. The administrator stated that he told her he was tired, and he would not be doing that again. The administrator stated that the Sheriff's department placed a on his

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A 025	Continued From page 3	A 025		

arm, it is a locator/ tracker for people with . The Sheriff's department calls it Project Life Saver. The administrator stated that she also placed a on his arm that tells the name of the facility, the residents name and the phone number to the facility.

On at 1:17 pm spoke with staff B, who stated that resident #1 had been sitting in the common area that morning with the other resident watching TV, it is something that he does every day. Staff B stated that about 9:50 am she went to see if resident #1 was ready for a snack. When staff B got to the common area resident #1 was not in the common area, so she asked staff A where was resident #1. Staff A responded that he had gone to his room to lay down. Staff B stated that she went to look for resident #1. Staff B stated that when she arrived in his room, resident #1 was not in the bed or his room. Staff B stated that she told staff A that he was not in his room, so they searched the entire facility but resident #1 was not anywhere inside.

At 1:26 pm staff B stated that she went outside to check the backyard and walked up to the top of the driveway. Staff B stated that she also took a left out of the driveway as well as walk down the road to a nearby a small pond, resident #1 was not anywhere to be found. Staff B stated that she went ... to the facility where she then called the administrator to let her know that resident #1 had eloped from the facility.

Staff B stated that the administrator arrived at the facility at 10:00 am. Staff B stated that she told the administrator what had happened. Staff B stated that the administrator called the police. Staff B stated that the police came out to the facility with a dog. The administrator told the

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A 025	Continued From page 4 police what happened, the police then went into resident #1's room with the dog. The administrator then called the family to let them know what was going on. Staff B stated that the police and the dog searched the property, and the dog led the police up to the bus stop. At 1:40 pm staff B stated that the police called during lunchtime and stated to the administrator that resident #1 had been found. Resident #1 was found downtown Kissimmee by the bus station. Staff B stated that resident #1 was happy and in good spirits when he returned to the facility but stated that he was not going to do such an outing again. Staff B stated that her biggest fear was something bad could have happened to him and she would never know how to forgive herself for it. On . . . at 2:02 pm staff A stated that she becomes nervous anytime she is reminded of the situation regarding resident #1. Staff A stated that staff B came to ask her where abouts of resident #1. Staff A stated that she told staff B that resident #1 stated he was tired and wanted to go . . . to his room to lie down. Staff B then came . . . and stated that resident #1 was not in his room. That is when they both began to search the entire facility, and he was nowhere to be found. Staff A stated that staff B went outside to search the backyard and then walked up to the top of the driveway to try and see if she locates resident #1. Staff A stated that staff B came . . . and stated she did not find resident #1, so she was going to call the administrator. At 2:12 pm staff A stated that when the administrator got to the facility, she immediately called 911. Staff A stated that it was during lunch the administrator got the call that	A 025		

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A 025	Continued From page 5 resident #1 had been found downtown Kissimmee at the bus station. Staff A stated that since the incident the administrator has implemented that resident checks must be conducted every half hour. On . . . . at 3:52 pm spoke with resident #1's sister who is the Power of Attorney (POA). Resident #1's sister stated that he does have and it was this behavior which caused her to place him at the facility. Resident #1's sister stated that before moving him to the facility he used to get up in the middle of the night and his apartment , 's parking lot, which worried his wife and herself. It was then that they decided to place resident #1 the facility. Resident #1's sister stated that he has been at the facility for the past two years and has never displayed any elopement behaviors. She stated that the facility seemed secure which is why she placed him there. Resident #1's sister stated that the care he receives from the facility is good, he seems happy content and she has no worries or concerns at this time. Photographic evidence obtained. Class III	A 025		