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
	AL11970185	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON MANOR OF MERRITT ISLAND	2250 N COURTENAY PKWY MERRITT ISLAND, FL 32953

(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
CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	CZ821		

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CZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	CZ821		

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CZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	CZ821		

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CZ821	Continued From page 3 to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to electronically submit to the Agency for Health Care Administration (AHCA,) a preliminary report within 1 business day and a full report within 15 days of 1 of 1 sampled resident eloping from the facility (#5). Findings: A review of resident #5's record revealed a facility admission date of . The resident's medical history included and (legally .) A and a health assessment form (1823) indicated the resident was not an elopement risk. On at 5:42 pm this resident and another resident were conversing at the front doors. The other resident left the building and told this resident he could not go with him. After the other resident left, this resident walked out the front doors saying he was going to walk to Poland. He was redirected inside. On at 11:11 am the resident put all his clothes in piles on the floor. He said he was packing to go home. He on top of the piles of	CZ821		

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CZ821	Continued From page 4 clothes. He then said his right thumb hurt. He was ambulatory with a walker. On at 2 pm the resident attempted to elope from the facility four times after his family left. The resident had a room change and was redirected multiple times. He was given , for , . He continued to attempt to leave the facility and became very agitated when he was redirected. He cursed at and tried to push staff away to get out of the facility. On at 5:03 pm the resident still made attempts to elope. The family was notified and will facetime the resident. On at 9:42 am the resident's health care provider was notified of the resident's refusal to take his medications for two days. The resident had increased and . On the resident was admitted to hospice with a diagnosis of of . On at 8 pm the resident walked outside the facility and resisted redirection inside. The family member was notified and assisted with coaxing the resident inside. On at 5:50 pm the resident was agitated, and the halls looking for an attorney to assist him with leaving the facility and said he was going to contact police. He attempted to enter other rooms. He was being escorted by staff for safety. He was adamant on leaving. Redirection was ineffective. gel was administered 30 minutes prior with no effect. He recently (past month or so) made regular attempts to elope with increased vigor while	CZ821		

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CZ821	Continued From page 5 experiencing [redacted] and when not experiencing them, generally beginning mid-afternoon. He begins sundowning with increasing frequency, verging on occurring on a regular basis. On [redacted] at 10:20 pm the nurse heard a brief alarm sound from the south door. The resident was standing there with his walker, dinner tray and wipes on the walker seat, saying "I'm ready to go home." It was explained to him that he could not leave the building, but he insistently wanted to go home. He was redirected to his room. On at 7:45 pm the staff were unable to locate the resident in the facility. All staff looked in rooms, public areas and recreation areas outside and were unable to locate him. Staff were alerted by the Sheriff's office the resident was found walking approximately one-tenth of a mile from the facility. Staff responded to the location and drove the resident to the facility. Upon his return staff conducted rounds on him every thirty minutes. On at 5 pm the resident was moved to the secured memory care unit. On at 1:51 am the resident became agitated and attempted to get out the door. On at 1:42 pm, a request was made of the administrator to provide the 1 and 15-day reports submitted to AHCA when resident #5 eloped. On at 2:20 pm, the administrator said the required reports were not submitted to AHCA for resident #5's elopement.	CZ821		

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CZ821	Continued From page 6 Unclassified	CZ821		
A 000	Initial Comments A complaint investigation (#2024008258) and a generator monitoring were conducted at Hampton Manor of Merritt Island on . The facility had deficiencies 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.	A 025		

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A 025	Continued From page 7 (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 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 provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for and injuries for 1 of 5 sampled residents and failed to provide adequate supervision to prevent the same resident from eloping (#5).	A 025		

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A 025	Continued From page 8 Findings: A review of resident #5's record revealed a facility admission date of . The resident's medical history included and (legally .) A health assessment form (1823) indicated the resident had a history of multiple and was unsteady. The and a 1823 indicated the resident was not an elopement risk. On at 2:10 am a caregiver heard a loud bang then the resident was observed sitting on the floor with his against a cabinet and the refrigerator. The resident refused to allow staff to assist him off the floor. He began speaking in polish and got up unassisted. He had a on the right side of his forehead and right . On at 4:14 pm the resident was found on the floor in the hallway by staff. The resident had an on the right side of his forehead. On the resident had a , , evaluation. On at 5:42 pm this resident and another resident were conversing at the front doors. The other resident left the building and told this resident he could not go with him. After the other resident left, this resident walked out the front doors saying he was going to walk to Poland. He was redirected inside. On at 1:45 am the resident had an unwitnessed in his room. He was found on the floor in front of his recliner during hourly rounds. A was seen on his right . On at 11:11 am the resident put all his	A 025		

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A 025	Continued From page 9 clothes in piles on the floor. He said he was packing to go home. He on top of the piles of clothes. He then said his right thumb hurt. On at 1:22 pm a housekeeper reported cleaning the resident's room when she turned around and saw the resident on the floor by his bed. The resident had a on his left and on his right . On at 7:20 am the resident was found on the floor between his bedroom and the bathroom. He said he was going to take a shower and lost his footing. He had an on his right . Staff encouraged him to ask for help, to which he replied he did not need help. On at 7:40 am staff observed the resident on the floor next to his bed. He said he . On at 2 pm the resident attempted to elope from the facility four times after his family left. The resident had a room change and was redirected multiple times. He was given for . He continued to attempt to leave the facility and became very agitated when he was redirected. He cursed at and tried to push staff away to get out of the facility. On at 5:03 pm the resident still made attempts to elope. On at 11:50 am the resident was heard yelling for help. He was observed laying on the floor with his on a pillow. When asked what happened he replied that he . He had a on his right and an on his right . He said his and hurt and said he hit his . He had a bump on the right side of his . The resident's family	A 025		

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A 025	Continued From page 10 member reported seeing on the camera inside the resident's room the resident at around 10:50 am. Staff was busy with other residents at that time. The resident was transported to a hospital. He returned to the facility on the same day. On at 9:42 am the resident's health care provider was notified of the resident's refusal to take his medications for two days. The resident had increased and . On at 7:27 am the resident reported that he attempted to sit on his walker, and it slid out from under him, causing him to . He had a on his left arm. On the resident was admitted to hospice with a diagnosis of of the . On at 7:05 pm the resident could be heard falling in his room. He tripped over his laundry basket and landed on his between the recliner and closet doors. On at 5:01 pm the resident had a while at the northwest corner of the building, near the exit door. On at 8 pm the resident walked outside the facility and resisted redirection inside. The family member was notified and assisted with coaxing the resident inside. On at 2:25 am the resident was seen sitting on the floor, perpendicular to the of his bed, bent at the and directed towards his closet. He had an on his mid right and right forehead. The resident said he	A 025		

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A 025	Continued From page 11 was sitting, attempted to stand, felt , then . On at 6:20 pm the resident had a witnessed in the dining room. He slipped and his shoes were wet. On at 5:50 pm the resident was agitated, and the halls looking for an attorney to assist him with leaving the facility and said he was going to contact police. He attempted to enter other rooms. He was being escorted by staff for safety. He was adamant on leaving. Redirection was ineffective. gel was administered 30 minutes prior with no effect. He recently (past month or so) made regular attempts to elope with increased vigor while experiencing , and when not experiencing them, generally beginning mid-afternoon. He begins sundowning with increasing frequency, verging on occurring on a regular basis. On at 10:20 pm the nurse heard a brief alarm sound from the south door. The resident was standing there with his walker, dinner tray and wipes on the walker seat, saying "I'm ready to go home." It was explained to him that he could not leave the building, but he insistently wanted to go home. He was redirected to his room. On at 8:55 am the resident had a in his room. The was heard by staff. The resident said he stood from his recliner, lost his balance then beside it. He had a on his left . On at 5:06 am the resident was found on his in front of his recliner. The resident said he could not get the recliner down.	A 025		

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A 025	Continued From page 12 On at 7:45 pm the staff were unable to locate the resident in the facility. All staff looked in rooms, public areas and recreation areas outside and were unable to locate him. Staff were alerted by the Sheriff's office the resident was found walking approximately one-tenth of a mile from the facility. Staff responded to the location and drove the resident to the facility. Upon his return staff conducted rounds on him every thirty minutes. On at 5 pm the resident was moved to the secured memory care unit. On at 1:51 am the resident became agitated and attempted to get out the door. On at 5 pm the resident was at the memory care door without his walker when he lost his footing while turning around and against the door. On at 2:03 am the resident was found sitting on the floor with his comforter. He was unable to say how he got on the floor. On at 7:19 am the resident was found on the floor in front of his closet. The resident said he slipped. He sustained an on his right outer and on his left inner . On at 11:02 am the resident was observed on the floor in his bathroom shower with his against the wall and folded. The resident said he . On at 9 pm the resident was found sitting on the floor in his shower. He was fully clothed	A 025		

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A 025	Continued From page 13 and unable to explain what happened. On . . . . at 5:15 pm the resident was walking to a chair in the living room and lost his balance and slid down the wall onto his . . . . . on the floor. On at 6:08 pm the resident had a and sustained a . . . on his right upper arm. On . . . . at 3:02 pm the resident had a . . He sustained a on his right and a . . . . . on the top left side of his . . . . On . . . . . at 7:49 am hospice was notified of the resident falling overnight. On at 5:32 pm the resident let go of his walker, lost his balance and . onto his left side in the dining room. On at 6:01 am the resident was found on the floor beside his bed. He sustained a . . . on his right . On at 6:09 pm a caregiver went into the resident's room to turn off the bed alarm. The resident got up from the bed, tried to reach for his razor, lost his balance and . backwards. He hit the of his on the nightstand and sustained a . . . under his left upper arm. On . . . . . hospice communication to the facility instructed to continue to monitor often for risks, bed alarm in place. On . . . . . at 10:14 am, the resident was seen sitting in a chair in the memory care dayroom. Staff were attending to him.	A 025		

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	AL11970185	A. BUILDING: _____ B. WING _____	08/22/2024

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A 025	Continued From page 14 The facility's [redacted] policy indicated the resident's service plan is updated as needed with interventions, an internal incident report is completed, the physician is informed of subsequent [redacted] and instability to discuss any interventions for care such as pharmacy review of medications, [redacted], etc. If the resident is falling frequently, 1 on 1 care may need to be requested. If [redacted] continue, relocation may be necessary. The service plan and [redacted] risk assessments will be reviewed and updated whenever a resident has a first [redacted], repeat and a [redacted] with injury requiring medical interventions/treatment. On [redacted] at 3:15 pm, the administrator said there were no [redacted] risk assessments for the resident. She said there was no additional documentation regarding the resident being identified as an elopement risk. No service plans and incident reports were provided. On [redacted] at 3:50 pm the resident was seen wearing a [redacted] risk bracelet. On [redacted] at 9:55 am, caregiver D said she worked on [redacted] when the resident eloped but she did know it happened because the resident lived on the assisted living side at the time, and she was working in memory care. The caregiver said the resident did have a history prior to the elopement of saying he wanted to leave and of packing his belongings. The caregiver said the resident [redacted] quite a bit before getting a walker. The caregiver said the resident was initially noncompliant with using it but had become more compliant since. On [redacted] at 11:10 am, caregiver C said she was working in memory care when the resident	A 025		

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A 025	Continued From page 15 eloped on . . . . . and was unaware the resident eloped. The caregiver said she briefly worked with the resident prior to that, and she never observed him try to leave nor had she heard him verbalize wanting to leave. She was unfamiliar with his . Attempts were made to speak with nurse E, nurse F, and caregivers G, H and I about the resident's elopement and without success. Class II	A 025		
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,	A 032		

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A 032	Continued From page 16 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 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	A 032		

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A 032	Continued From page 17 interviews, the facility failed to ensure 1 of 1 sampled resident (#5) who eloped from the facility had identification (ID) on their person that included their name and the facility's name, address, and telephone number and failed to conduct a minimum of two resident elopement drills during 2023. Findings: A review of resident #5's record revealed that on at 7:45 pm the staff were unable to locate the resident in the facility. All staff looked in rooms, public areas and recreation areas outside and were unable to locate him. Staff were alerted by the Sheriff's office the resident was found walking approximately one-tenth of a mile from the facility. Staff responded to the location and drove the resident to the facility. Upon his return staff conducted rounds on him every thirty minutes. On at 5 pm the resident was moved to the secured memory care unit. On at 1:42 pm a request was made of the administrator to provide all elopement drills conducted during 2023 and 2024. On at 2:15 pm, the administrator said the only elopement drill she could provide was one conducted on . On at 3:50 pm, resident #5 was seen in the memory care common area. He did not have an ID on him. Nurse B said the facility did not use ID bracelets or any other method of ID for residents at risk for elopement. The facility's elopement policy indicated	A 032		

Agency for Health Care Administration

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A 032	Continued From page 18 the facility must make, at a minimum, a daily effort to determine that at risk residents have ID on their person that includes their name, the facility's name, address and phone number. The policy also indicated elopement drills should be conducted once every six months. Class III	A 032		