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
	AL11967559	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CASA ASSISTED LIVING	220 N GROVE STREET 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
A 000	Initial Comments Two (2) Complaint Investigation #2024010033, #2024011159 and a generated monitoring was conducted at La Casa Assisted Living & Memory Care on . . . . . The facility had deficiencies at the time of the survey visit.	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. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	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 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 record review and interview, the facility failed to provide appropriate supervision for 1 of 4 sampled residents (#1) to prevent an elopement from a secured memory care facility. Findings: Resident #1's record review revealed an admission date of [redacted]. The last 1823 Health Assessment dated [redacted] listed medical history of [redacted] and [redacted]. His [redacted] status was	A 025		

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A 025	Continued From page 2 . . . . . occasionally. He needs supervision with bathing and grooming. He is independent in all other activities of daily living. He needs assistance with self-administration of medications. Resident #1 was identified as high risk for elopement. A facility report documented Resident #1 was missing and eloped from the Memory Care unit and found approximately 5 miles away on a major highway 520 and taken to the emergency room. The resident was discharged from the hospital at 6AM. Law enforcement called the facility to inform them Resident #1 eloped and they will be returning him . . . to the facility at 9 AM. A facility note dated . . . . . at 7 PM, Resident #1 was last seen eating his dinner in the Memory Care dining room. There was no documented evidence of an elopement monitoring check from at 7 PM to . . . . . 5:45 AM (a 10.5-hour gap) by Caregiver B working the overnight shift. A facility note dated at 5 AM, Caregiver B called out to Resident #1 to come get his early medication. While waiting for Resident #1, Caregiver B went to assist another resident with care. A facility note dated at 5:45 AM, Caregiver B discovered that the side door was unlocked, and Resident #1 was not in the facility. Caregiver B searched the facility and surrounding area. A facility note dated at 6:45 AM, Caregiver B called 911 (one hour later) and called the Administrator at 7AM and notified the family	A 025		

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A 025	Continued From page 3 member via telephone at 7:40 AM. A review of the law enforcement report dated at 7:47 AM documented that the elopement was dispatched on . . . . . at 10 PM. A male caller called a report in that a man (#1) was near their home near A1A (about 5 miles from the facility) and stated that the man (#1) was . . . . . saying he was trying to get to Melbourne, Florida (about 45 minutes away). The Deputy returned resident #1 . . . to the facility at 9 AM. Resident #1 was unaccounted for from the Memory Care for over 12 hours. A review of the hospital note showed that Resident #1 was admitted to the emergency room on . . . . at 1:15 AM and discharged at 6 AM. A facility note on . . . . . documented that the Maintenance Director found Resident#1's elopement bracelet in a vacant resident room. Resident #1 had cut it off. On at 2:30 PM, an interview with the Wellness Nurse confirmed that Resident #1 had left outside the unlocked side door in Memory Care that leads to the front of the facility that Caregiver B failed to check. Furthermore, the Wellness Nurse completed an internal investigation and determined that Caregiver B was asleep during her overnight shift and did not secure the unit and check on residents. Caregiver B was reprimanded and no longer works at the facility. Due to caregiver B not checking on the resident between 7:00 PM and 5:00 AM the exact time the resident eloped is unknown.	A 025		

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A 025	Continued From page 4 On at 4:20 PM, an interview with the Administrator confirmed the findings. (Photographic Evidence Obtained) Class II	A 025		