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
	AL11970027	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL VISTA ASSISTED LIVING INC	4922/4924 JORDAN AVE S LEHIGH ACRES, FL 33973

(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 # 2023016004 and emergency power plan monitoring survey, was conducted on , at Royal Vista Assisted Living, Inc., an assisted living facility, in Lehigh Acres, Florida. Complaint # 2023016004 was substantiated at 0025 and 0032. The following is a description of the deficiencies. .	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 , , 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	A 025		

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A 025	Continued From page 1 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 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 staff interview, facility failed to provide adequate supervision for 1 (Resident #1) of 3 residents reviewed. Failure to provide adequate supervision resulted in Resident #1's elopement on . The findings included:	A 025		

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A 025	Continued From page 2 Record review revealed resident #1 was admitted to the facility on . The Resident Health Assessment Form 1823, indicated diagnoses of , and . The or behavioral status indicated Resident #1 was forgetful at times. Resident #1 eloped from the facility on . Staff A was alone in the facility with a total of 4 residents, including Resident#1. Staff A was busy providing care to one of the residents when Resident #1 opened the door and left the facility. About 30 minutes after the incident, Resident #1 was found by the police and returned to the facility. During an interview with Staff A on at 10:00 a.m., she confirmed, she was alone in the facility with a total of 4 residents including Resident #1. Staff A said she was toileting a resident when Resident #1 opened the entrance door and left. Staff A said she was not aware Resident#1 was not there up to the moment, the resident was found and returned to the facility by the police. During an interview with the Administrator on at 11:30 a.m., he confirmed Resident #1 eloped from the facility on , and staff was unaware that Resident #1 was not on the premises until he was returned to the facility by the police. . Class III	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards	A 032		

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A 032	Continued From page 3 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 resident's representative. (b) Facility Resident Elopement Response	A 032		

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A 032	Continued From page 4 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 review, and staff interview, the facility failed to ensure residents deemed as an elopement risk have identification on their persons that includes their name, the facility's name, address, and telephone number for 3 (Resident #1, #2, #3) of 3 residents reviewed for elopement. The facility failed to ensure the Elopement policy and procedure reflected and included language indicating, residents deemed as elopement risk were to have identification on their persons that included their name, the facility's name, address, and telephone number. The findings included: Review of facility Policy and procedure titled:	A 032		

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A 032	Continued From page 5	A 032		

elopement revealed the facility Elopement policy and procedure did not indicate and or included the language that residents deemed as an elopement risk were to have identification on their persons that includes their name, and the facility's name, address, and telephone number.

Resident #1 eloped from the facility on . Staff A was alone in the facility with a total of 4 residents. Staff A was busy providing care to one of the residents, when Resident #1 opened the door and left the facility. About 30 minutes after the incident Resident #1 was found by the police and brought to the facility.

During an interview with Staff A on at 10:00 a.m., she confirmed she was alone in the facility with a total of 4 residents including Resident #1. Staff A said she was toileting a resident when Resident #1 opened the entrance door and left. Staff A said she was not aware Resident#1 was not in the facility up to the moment Resident #1 was found, and returned to the facility by the police. Staff A said Resident #1 did not have any identification on his person after the incident, and the facility currently have 2 other residents deemed as an elopement risk, Resident #2 and Resident #3.

Record review revealed Resident #2 was admitted to the facility on . The Resident Health Assessment form 1823 for Resident #2 dated , indicates Resident #2 as an elopement risk.

Record review revealed Resident #3 was admitted to the facility on . The Resident Health Assessment form 1823 for Resident #3 dated , indicates Resident #3 as an

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A 032	Continued From page 6 elopement risk. Observations of Resident #2 and Resident #3 on at 10:10 a.m., revealed Resident #2 and #3 had no identification on their person that included their name, and the facility's name, address, and telephone number. Both residents confirmed at time of the observation they do not have any identification on their person with their names, and the facility's name, address, and telephone number. During an interview with the Administrator on at 11:40 a.m., he confirmed, Resident #1, #2, and #3 were deemed as elopement risks, and did not have any identification on their person with their names, the facility's name, address, and telephone number. The Administrator said he provided them with the facility's business card, to use in place of identification, because he thought that was sufficient. . Class III	A 032		