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
	AL11968971	A. BUILDING: _____ B. WING _____	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DISCOVERY VILLAGE AT SARASOTA BAY LLC	1414 W 69TH AVE BRADENTON, FL 34207

(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 (#2024012669, 2024014823, 2024015360) in conjunction with a generator monitoring visit was conducted at Discovery Village at Sarasota Bay on . Deficiencies were identified at the time of the visit.	A 000		
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	A 032		

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A 032	Continued From page 1 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 review, and interviews, the facility failed to follow their resident elopement response policy and procedure that included at a minimum an immediate search of the facility and premises, the identification of staff responsible for implementing each part of the elopement response policy and procedures and	A 032		

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A 032	Continued From page 2 specific duties and responsibilities, and the identification of the staff responsible for contacting law enforcement, the resident's responsible party, the case manager, and the State Agencies. Findings Included: During a record review conducted on the facility's Elopement policy that is dated , states the following: If an elopement occurs the following steps will be immediately initiated: - Notify the Executive Director and Director of Health and Wellness immediately. - Begin a systematic search of the property and surrounding neighborhood. A thorough search of the property will include searching: 1. All public areas. 2. Bathroom areas. 3. Bedroom closets. 4. Under beds. 5. Window areas - check to ensure windows were not used as an exit 6. Automobiles on the property and surrounding area. - Notify the residents' family and/or responsible party. - Notify law enforcement/Emergency Medical Services (911) within thirty (30) minutes of the elopement if the resident is not located. During an interview conducted on at 9:18am with the Memory Care Director (MCD), they stated that Resident #2 was exit seeking prior to the incident. They stated that when the door is pushed on for 30 seconds, it will sound	A 032		

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A 032	Continued From page 3 the alarm and open. The MCD stated that Resident #2 pushed the door for 30 seconds, set the alarm off, and then exited the facility. The MCD stated that another resident at the same time the alarm was going off. The MCD stated that Staff C silenced the door alarm while looking for another staff member to help with the resident that . The MCD stated that the staff members on shift did not look for anyone that could have exited the door. The MCD stated that no one knew the resident was missing until the police called the facility an hour and a half later stating they had the resident in their custody. The MCD agreed they did not search for the missing resident, and did not notify the Power of Attorney or the Police because they did not realize the resident was missing. During a record review conducted on of Resident #2's Health Assessment form, AHCA Form 1823, the resident has diagnoses of PNA, HLD, Overactive , Dry , , , , , , , , , , , , , and . The resident was marked as an elopement risk. During an interview conducted on at 10:30am with the Administrator, they stated that Resident #2 pushed the door for 30 seconds, the alarm went off, and the resident eloped from the facility. The Administrator stated that Staff C was "one-track minded" after the incident of another resident falling, and turned off the alarm and did not look for any resident that could have eloped. The Administrator agreed the facility did not contact the Police or the Power of Attorney since they did not know the resident was missing. The Administrator agreed that no one looked for the resident.	A 032		

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A 032	Continued From page 4 Photographic Evidence Obtained. Class III	A 032		