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
	AL11969035	A. BUILDING: _____ B. WING _____	R 12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA SENIOR LIVING OF PALM BAY	3490 GRAN AVE PALM BAY, FL 32905

(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 re-visit survey was conducted at Grand Villa Senior Living in Palm Bay, Florida on . The facility had an uncorrected de deficiency that remained uncorrected.	{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 resident diets in accordance with Rule	{A 025}		

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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 record reviews and interviews, the facility failed to ensure appropriate supervision and the general whereabouts of each resident for1 of 3 sampled residents (#2) who was found outside unattended. Findings: A review of resident #1's record revealed a facility admission date of . The resident's medical history included , , of right , fatigue and history of injury. The resident needed assistance with self-administration of medications. The resident is	{A 025}		

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{A 025}	Continued From page 2 a risk due to . The resides in the memory care unit. On at 1:50pm Staff A was asked to explain the event that took place on which involved resident #2. Caregiver A stated that resident #2 resides on the locked memory care unit. However, resident #2 has a neighbor/family friend that the immediate family has given permission to come and visit the resident from time to time. On that day the friend and resident #2 went for a walk outside of the facility as they usually do. That day the friend did not bring resident #2 into the building and take her up to the memory care unit. She left her outside on the bench by the front door and drove away, when the friend drove away the resident got up and began to walk toward the of the building. It was the maintenance director that brought resident #2 into the building and notified the Assistant Executive Director ( ). They tried to call the friend but was not able to get her on the phone. Staff A did get in touch with the family member for resident #2. Staff A stated that she advised the family member to not allow that familiy friend to take resident #2 out of the facility, so that this incident will not occur again. On at 2:32pm the maintenance director was asked to explain what took place with resident #2 on . The maintenance director stated that a provider was coming into the facility and saw him walking out the front door and told him there was a resident that was walking towards the of the facility. The maintenance director stated that when he got to the side of the building resident #2 was wondering the parking lot alone. He was able to	{A 025}		

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{A 025}	Continued From page 3 re-direct the resident and bring resident #2 into the building and brought her to the assistant executive directors' office. On at 2:47pm, the Assistant Executive Director ( ) confirmed that resident #2 was involved in an elopement. The stated when the maintenance director brought the resident into her office and after hearing the resident was found in the parking lot she immediately checked the camera footage. It was then that she realized resident #2 was signed out with a family friend. The family friend and the resident went for a walk, upon the two coming onto the premises the friend did not bring resident #2 into the building. However, the friend left resident #2 sitting on the bench outside the facility. The family friend then got into her car waved goodbye to resident #2 and drove away. Resident #2 got up and began to walk the parking lot of the facility. It was a provider that was coming into the building to see residents told the maintenance director that a resident was on the side of the building. The said she immediately called the resident's daughter to get the number for the family friend, and to also let her know what had transpired with her mother and the facilities recommendation for that friend visiting. The stated that when she had finally gotten to speak with the family friend, the lady stated that the resident had told her she just wanted to sit outside and catch her breath after their walk, and she would go inside. The stated that she reminded the family friend resident #2 had . The facility's elopement policy was requested. The policy defines elopement as a situation in which the resident's whereabouts are unknown or	{A 025}		

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{A 025}	Continued From page 4 the resident leaves the community, also team members should maintain a general awearness of the residents whereabouts. On at 5:45 pm, the administrator and the risk management nurse stated that the elopement of resident #2 should not be held against them because the resident was signed out by the family friend. It was explained to the administrator that the resident was taken from a locked unit and left in their parking lot, and although she was signed out the resident is still the facilities responsibility to know the whereabouts of the resident at all times. Also, it is their responsibility to educate staff, friends and the resident's family on the importance of a memory care unit and the residents safety. Photographic Evidence Obtained. Class II	{A 025}		