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
	AL11969117	A. BUILDING: _____ B. WING _____	R 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET STREET VIERA	6845 MURRELL RD MELBOURNE, FL 32940

(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 revisit to a re-licensure survey with complaint #2025000545 and a generator monitoring were conducted on at Market Street Viera Assisted Living Facility. A deficiency remained uncorrected 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. (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}		

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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: DEFICIENCY REMAINED UNCORRECTED Based on observation, record reviews, and interviews, the facility failed to provide adequate supervision and provide care and services appropriate to meet the needs of residents by failing to prevent elopement from a secure memory care unit for 1 of 1 residents sampled (#14). Findings: On Sunday at 3:41pm resident #14 eloped from the secure memory care facility	{A 025}		

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{A 025}	Continued From page 2 through an unlocked exit door. A review of resident #14 record revealed he was admitted on . His record contained a Resident Health Assessment form (1823) dated . His diagnoses included severe with nonsensical speech. He was assessed to be an elopement risk. The resident was independent with ambulation and transfer. He required supervision with bathing, eating, and toileting. The resident required assistance with and grooming. He also required assistance with self-administration of medication. A review of the facility notes found: On documented at 4:21 pm by nurse (C) - Receptionist (H) came into plaza asking for assistance to get resident #14 inside from the patio. The count of all residents was conducted. The resident was assessed and had no injury. Fifteen (15 minute) well checks were initiated for 72 hours for the resident. On documented at 4:16pm by nurse (C) resident walks around continuously. He is hard to redirect. On at 11am the Administrator confirmed in an interview, resident #14 exited through the sunroom door in Blossom House. She said the door was not locked because the power went off and the lock was disengaged. She was not in the facility at that time but said the magnet alarm did not go off when the door was opened. On at11:10am Resident #14 was observed around the common area. He walked independently without any assistive device. He was unable to recall the elopement due to	{A 025}		

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{A 025}	Continued From page 3 decline and nonsensical speech. On at 12:15pm in an interview with receptionist (H) he said on he noticed resident #14 sitting outside the secured door under the entrance porch. He recalled being in the restroom for about 10 minutes. He did not notice the resident before leaving the reception desk. While in the restroom he did not hear any doors open. After noticing resident #14 he advised the care staff so they could assist the resident inside. He said he checked the cameras at the front and door and did not see resident #14 exiting during the time he was away from the desk. The sunroom doors do not have cameras. He did not know who found the sunroom door unlocked. He did recall the power flickering off around :30am that morning. He stated that could have made the doors unlock. A review of the facility Missing Person Elopement policy/procedure dated did not indicate what staff should do if the exit alarms are activated. The policy/procedure documented what should be done after identifying a resident's whereabouts were unknown. On at 12:45pm the administrator confirmed with the maintenance director that the alarm was in fact working. When staff went to the alarming door, they did not see any residents. They closed the door to stop the alarm but did not initiate a resident count or search. The Administrator was unable to confirm how long the resident had been out of the secure facility. She did confirm he was at risk due to his diagnosis of severe . (Photo Evidence Unknown)	{A 025}		

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{A 025}	Continued From page 4 Class II	{A 025}		