STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967791	12/10/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
A Banyan Residence	100 Base Ave East Venice, FL 34285	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0007 - 58a-5.0181(1) Fac - Admissions - Criteria S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= G
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D

Specific Tag Findings:
These are the results of an ununnounced Complaint Survey, CCR# 2013012707 which was conducted on , at A Banyan Residence, an Assisted Living Facility (ALF).

The following is a description of non compliance:

0007-Admissions - Criteria 58A-5.0181(1) FAC
Based on record review and interview, the facility's Administrator failed to properly assess 1 (Resident #1) of 3 sampled residents.

The findings include:

The Assistant Administrator stated during interview conducted on at 10:10 a.m. that Resident #1 was admitted to the facility having a life saver bracelet. She stated that the resident had a car accident and obtained damage that resulted in memory loss, especially short term memory loss. She stated that the resident's legal guardian (sibling) and parents insisted on having the bracelet since the resident had a tendency to wonder and liked to walk out on the patio at all time. She said that family did not share any prior elopement history.

Even though the resident was admitted to the facility with a life saver bracelet and had history of wondering, he was not identified as a high risk of elopement.

The Assistant Administrator stated during an interview conducted on at 1:45 p.m., that Resident #1 was not deemed as high risk of elopement since no history of elopements was provided to her by the family upon the resident's admission to the facility.

Class III

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review and interview, the facility failed to provide appropriate supervision for 1 (Resident #1) of 3 sampled residents.

The findings include:

On , at 8:46 p.m., Resident #1 forced the exit door open and left the facility. Video camera view of the incident revealed the resident pushed the door repeatedly and tapped the magnet multiple times. He ended up de-activating the magnet. He opened the door and exited the facility. Resident #1 appeared agitated on the video. The time observed on the video was 7:46 p.m. However, the Assistant Administrator stated during an interview, conducted on , at 10:00 a.m., this was a system error and the actual time of elopement was 8:46 p.m.

According to the Assistant Administrator, during interview conducted on at 10:10 a.m., the facility has a

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system in place that all residents need to be monitored on two hour intervals.

Resident #1 lived in the first building. There was only one staff working at the time in the first building, that was Staff A.

Staff A was responsible of conducting a resident physical check every two hours. The check was to take place at 9:00 p.m. Staff A told the Assistant Administrator she forgot to check the census because she was too busy assisting another resident take a shower. She then went to the main dining area and began folding napkins.

The Assistant Administrator stated on [redacted] at 11:00 a.m., this was an oversight on Staff A's part and she was written up as a result of the elopement incident.

Review of the Medication Observation Record (MOR) for Resident #1 revealed the resident was to receive medications at 8:00 p.m. On the back of the MOR it stated all PM medications were not given because the resident was out of the building.

The Assistant Administrator stated during interview conducted on [redacted] at 12:48 p.m. she was unaware of the documentation. The Assistant Administrator called the Med. Tech responsible, Staff B, on [redacted] at 12:55 p.m. He said, during the telephone interview at 12: 55 p.m., he was running late with medications that night. He did not provide an explanation. He said he went to Resident #1's [redacted] 10:00 p.m. to give him his medications. He could not find him. He then talked to Staff A and they both started looking for the resident. At 10:30 p.m. they called Staff C, the resident aid on call. They did not call the administrator. At 10:42 p.m. they called the Assistant Administrator.

Review of the facility elopement policy and procedure revealed staff was to notify both the Administrator and the Assistant Administrator immediately. Staff on the premises did not follow the facility's elopement policy.

Initially, the following statement was given by staff present and it was recorded on the incident report as follows: "Around 10:25 p.m. (time for his PM medication) Staff B realized that Resident #1 was absent. The staff followed elopement policy and began searching the building. The Administrator and Assistant Administrator were immediately notified."

Staff retracted the initial statement during telephone interview with the Assistant Administrator and admitted they found out Resident #1 was missing around 10:00 p.m. and not 10:25 p.m. and staff did not follow facility's elopement policy and procedure.

At 11:00 p.m., the police was notified and a helicopter search along with car search began. Due to his [redacted] and short memory loss diagnosis, Resident #1 had a life saver bracelet placed on his ankle. The representative responsible for life saver program was notified immediately. She arrived in the facility around 1:00 a.m. and activated the GPS device. At the same time police stopped the helicopter search since it was dark outside. Resident #1 was found the next day around 11:30 a.m. about 1 and ½ mile away from the facility close to the shore. He was covered in mud and was not visible since he was lying in the mud under mangroves. The police transferred the resident to Venice Regional Hospital where he currently is hospitalized with diagnosis of [redacted] and a [redacted] on his back.

The Assistant Administrator stated during interview, conducted on [redacted] at 10:10 a.m., Resident #1 was admitted to the facility having a life safety bracelet. She stated Resident #1 had a car accident and obtained [redacted]

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damage that resulted in memory loss, especially short term memory loss. She stated Resident #1's legal Guardian (sibling) and parents insisted on having the bracelet since the resident had a tendency to wander and liked to walk out on the patio at all times. She said the family did not share any prior elopement history. Even though Resident #1 was admitted to the facility with a life saver bracelet and had history of wandering, he was not identified as a high risk of elopement.

The Assistant Administrator stated during interview conducted on at 1:45 p.m., Resident #1 was not deemed as high risk of elopement since no history of elopement was provided to her by the family upon the resident's admission to the facility.

The Assistant Administrator acknowledged on at 3:00 p.m., staff present did not follow facility's elopement policies and procedures and Resident #1 was not appropriately assessed as high risk of elopement.

The census on the day of the event was 47 residents. Staffing record review for the day of the incident revealed a total of 5 direct care staff at the time of the incident.

The facility structure consists of 4 connected buildings. The first building consist of residents and only one caregiver was present. Then there is the main living/dining/activity area where the med. tech is. Then there is one more building with resident and there was one caregiver there. Then there is the memory unit where there are 2 staff present.

At the time of the incident there was only one staff in the first building where Resident #1 was, but this staff was busy giving a shower to another resident.

Lack of appropriate resident assessment, lack of magnet replacement at the front gate, and lack of supervision of an agitated resulted to Resident #1's elopement.

Class II

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC
Based on record review and interview, the facility failed to follow its elopement policies and procedures and failed to properly identify 1 (Resident #1) of 3 sampled residents as high risk for elopement.

The findings include:

On at 8:46 p.m., Resident #1 forced the exit door open and left the facility. Video camera view of the incident revealed the resident pushed the door repeatedly and tapped the magnet multiple times. He ended up de-activating the magnet. He opened the door and exited the facility. Resident #1 appeared agitated on the video. The time observed on the video was 7:46 p.m. However, the Assistant Administrator stated during an interview conducted on at 10:00 a.m. this was a system error and the actual time of elopement was 8:46 p.m.

According to the Assistant Administrator during an interview conducted on at 10:10 a.m., the facility has a system in place all residents need to be monitor on two hour intervals.

Resident #1 lived in the first building. There was only one staff working at the time in the first building, that was Staff A.

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Staff A was responsible of conducting a resident physical check every two hours. The check was to take place at 9:00 p.m. Staff A told the Assistant Administrator she forgot to check the census because she was too busy assisting another resident take a shower.

The Assistant Administrator stated on , at 11:00 a.m., this was an oversight on Staff A's part and she was written up as a result of the elopement incident.

Review of the Medication Observation Record (MOR) for Resident #1 revealed the resident was to receive medications at 8:00 p.m. On the back of the MOR it stated all PM medications were not given because the resident was out of the building.
The Assistant Administrator stated, during interview conducted on , at 12:48 p.m. that she was unaware of the documentation. The Assistant Administrator called the med. tech responsible, Staff B, on , at 12:55 p.m. He said, during the telephone interview at 12:55 p.m. he was running late with medications that night. He did not provide an explanation. He said he went to Resident #1's 10:00 p.m. to give him his medications. He could not find him. He then talked to Staff A and they both started looking for the resident. At 10:30 p.m., they called Staff C, the resident aid on call. They did not call the Administrator. At 10:42 p.m. they called the Assistant Administrator.

Review of the facility elopement policy and procedure revealed staff was to notify both the Administrator and the Assistant Administrator immediately. Staff on the premises did not follow the facility's elopement policy.

Initially, the following statement was given by staff present and it was recorded on the incident report as follows: "Around 10:25 p.m. (time for his PM medication) staff B realized that Resident #1 was absent. The staff followed elopement policy and began searching the building. The Administrator and Assistant Administrator were immediately notified."

Staff retracted the initial statement during telephone interview with the Assistant Administrator and admitted they found out that Resident #1 was missing around 10:00 p.m. and not 10:25 p.m. and staff did not follow facility's elopement policy and procedure.

At 11:00 p.m., the police was notified and a helicopter search along with car search began. Due to his and short memory loss diagnosis, Resident #1 had a life saver bracelet placed on his ankle. The representative responsible for life saver program was notified immediately. She arrived in the facility around 1:00 a.m. and activated the GPS device. At the same time police stopped the helicopter search since it was dark outside. Resident #1 was found the next day around 11:30 a.m. about 1 and ½ mile away from the facility close to the shore. He was covered in mud and was not visible since he was lying in the mud under mangroves. The Police transferred the resident to Venice regional Hospital where he currently is hospitalized with diagnosis of and a on his back.

The Assistant Administrator stated, during interview conducted on , at 10:10 a.m., Resident #1 was admitted to the facility having that bracelet. She stated Resident #1 had a car accident and obtained damage that resulted in memory loss, especially short term memory loss. She stated Resident #1's legal Guardian (sibling) and parents insisted on having the bracelet since the resident had a tendency to wander and liked to walk out in the patio at all time. She said the family did not share any prior elopement history. Even though Resident #1 was admitted to the facility with a life saver bracelet and had history of wandering, he was not identified as a high risk of elopement.

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The Assistant Administrator stated, during interview conducted on [redacted] at 1:45 p.m. Resident #1 was not deemed as high risk of elopement since no history of elopements was provided to her by the family upon the resident's admission to the facility.

The Assistant Administrator acknowledged on [redacted] at 3:00 p.m. staff present did not follow facility's elopement policies and procedures and Resident #1 was not appropriately assessed as high risk of elopement.

Class II

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on record review and interview, the facility failed to follow appropriate procedure when assisting Resident #1 with self-administration of medications.

The findings include:

Review of the Medication Observation Record (MOR) for Resident #1 revealed that the resident was to receive medications at 8:00 p.m. On the back of the MOR it stated that all PM medications were not given because resident was out of the building.

The Assistant Administrator stated during interview conducted on [redacted] at 12:48 p.m. that she was unaware of the documentation. The Assistant Administrator called the med. tech responsible, Staff B, on [redacted] at 12:55 p.m. He said, during a telephone interview at 12:55 p.m. that he was running late with medications that night. He did not provide an explanation. He said that he went to Resident #1's [redacted] 10:00 p.m. to give him his medications.

The Administrator acknowledged on [redacted] at 3:00 p.m., that Resident #1 did not receive his medications in a timely manner (one hour before up to one hour after the prescribed time).

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
A Banyan Residence
100 Base Ave East
Venice, FL 34285

Dear Administrator:

This letter reports the findings of a complaint 2013012707 inspection survey conducted on , 2013, by a representative of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0007 - 58a-5.0181(1) Fac - Admissions - Criteria S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= G
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D

Directed Corrective Actions: The Assisted Living Facilty is required to:

1. Within 48 hours, a Registered Nurse must conduct a facility-wide elopement risk assessment of all the residents in the facility and refer any resident to their Health Care Provider if their health condition status has changed since their last Health Assessment was performed. Ensure all residents meet the continued residency criteria.

2. The facility will re-train all staff on elopement procedures and conduct elopement drills on all shifts and include all staff. This training and these elopement drills will be completed by no later than , 2014.

3. Increase staffing to a minimum of 2 qualified care staff in all sections on each shift and maintain written work schedules for review. This will be accomplished by no later than , 2014.

3. Implement an hourly observation log of all residents by no later than , 2014.

Headquarters
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Tallahassee, FL 32308
http://ahca.myflorida.com

Fort Myers Field Office
2295 Victoria Avenue,
Fort Myers, FL 33901
Phone (239) 335-1315; Fax (239) 338-2372

4. Assess facility policy and practice of the periotic checks of residents, with special emphasis on residents not on the secured unit, all admissions in the last 30 days, all new admissions, and residents with significant changes and behavioral patterns of exit seeking. This will be completed by the Administrator no later than 2014.

5. Test all exit doors, including the front gate, daily and maintain log for review.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call Catherine Anne Avery, Survey and Certification Support Branch, at (850) 412-4505.

Sincerely,

Harold D. Williams
Field Office Manager

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