STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964457	02/23/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Greenbriar Retirement	3615 McNeil Road Apopka, FL 32703	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
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= D
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments
Complaint inspection CCR#2013012438 was conducted on and

Greenbriar Retirement had deficiencies found at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review and interview the facility failed to provide adequate supervision and have general awareness of resident, with a diagnoses of whereabouts at all times for 1 of 3 sampled residents (#1).

Findings:

The Agency for Healthcare Administration received information that resident #1 eloped from the facility on

Record review for resident #1 revealed and an Assisted Living Facility Health Assessment Form (1823) updated on that indicated diagnoses of and stated the "patient wanders". Review of the 1823 dated indicated due to acute , calm, and not combative. The resident needed supervision with all activities of daily living and stated the resident was very "forgetful and patient wanders around".

Review of facility notes revealed:

last seen at 7:30 was about to notify administrator and family, but received a call from the family member that resident #1 was with the police. The police stated resident #1 was found at "Bearlake".

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Interview with Staff B, caregiver on [redacted] at 2:05 PM who stated at around 7:30 PM she looked around to check the residents. She noticed that resident #1 was gone. At 7:30 PM, the phone rang; it was resident #1's family member who called. The family member asked her if I she knew that resident #1 was with that family member. The family member stated the police called him to let him know that resident #1 was not at the facility, he was with the police officer. The police brought the resident back to the facility. The resident was gone from around 7 PM. He was ok when he got back. He did not wander or exit seek anymore. Sometimes he was [redacted] When he got back to the facility, he said he just walked and he was looking for his family member. The family member lived close by the facility.

Phone interview with family member on [redacted] at 12:20 PM who stated the resident had [redacted] He further stated a man was doing work on the facility and left the front door open. The resident walked over a mile, to State Road 436 (a busy multi-lane highway). He was gone longer than 30 minutes. He called the facility to let them know the resident was gone, and told them the resident was at his house with the police. The facility was not aware. He was out at least an hour, he was a slow walker. The resident knew the family member's name, so the police ran his name and they found him.

Review of the Seminole County Sheriff's Office Elder Intervention Report #20133211802 dated [redacted] at 23:18 (11:18 PM) stated on, [redacted] at approximately 7:34 PM, I arrived in the area of SR 436 & Bear Lake Rd, Apopka, Seminole County, FL in reference to an elder male who said he was lost."

Upon my arrival I observed an elderly white male shuffling westbound on the north side of SR 436 just west of Bear Lake Road. I made contact with the male who was positively identified as resident #1. He stated he had left his family member's house to go for a walk and he was lost. He also said he did not want to go home but stated several times he wanted to go to his family member's residents. The resident was unable to tell him where his home was but that he was supposed to be with his family member. He was taken to the address listed, but the resident said he no longer lived there. The family member's address was located and the resident was taken to his residence. Upon our arrival there I spoke with the family member who stated the resident suffered from [redacted] and he lived in Greeenbriar Retirement home. The family member was very alarmed the resident had wandered out and they had not received a call from the facility letting them know he was missing.

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After speaking with the resident family, he was taken back to the facility. Contact was made with Staff B, who was the only person in charge of 21 residents. She did not seem to be upset that the resident had left their secure facility and had been missing. Staff B stated there were people working in the building and that must have been when he left. She also stated she did not know he was gone as he usually locked his door. Staff B stated her shift started at 7 PM and there were usually two people at the facility, not one.

The resident had mobility issues and did not walk very fast. He was found one mile from the facility and it was believed he was gone around 30 minutes to an hour before being in contact with law enforcement. The resident was returned to the facility at 8:18 PM and at no time did they realize he was missing until being notified by the family member who spoke with him.

Interview with the Assistant administrator on [redacted] at approximately 11:45 AM who stated the resident was not at risk of elopement anymore.

Class II

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC
Based on observation and interview the facility failed to ensure a resident with any history of elopement had identification (ID) on their person that included their name, the facility's name, address and telephone number for 1 of 3 sampled residents (#1).

Findings:

Record review for resident #1 revealed and Assisted Living Facility Health Assessment Form (1823) updated on [redacted] that indicated diagnoses of [redacted] and stated the "patient wanders". Review of the 1823 dated [redacted] indicated [redacted] due to acute [redacted], calm, [redacted] and not combative. The resident needed supervision with all activities of daily living and stated the resident was very "forgetful and patient wanders around".

Review of facility notes revealed:

[redacted] last seen at 7:30 was about to notify administrator and family, but received a call from the family member that resident #1 was with police. Police stated that resident #1 was found at "Barelake".

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Phone interview with family member on [redacted] at 12:20 PM who stated the resident had [redacted] He further stated a man was doing work on the facility and left the front door open. The resident walked over a mile, to State Road 436 (a busy multi-lane highway). He was gone longer than 30 minutes. He called the facility to let them know the resident was gone, and told them the resident was at his house with the police. The facility was not aware. He was out at least an hour, he was a slow walker. The resident knew the family member's name, so the police ran his name and they found him.

Review of the Seminole County Sheriff's Office Elder Intervention Report #20133211802 dated [redacted] at 23:18 (11:18 PM) stated on, [redacted] at approximately 7:34 PM, I arrived in the area of SR 436 & Bear Lake Rd, Apopka, Seminole County, FL in reference to an elder male who said he was lost."

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After speaking with the resident family, he was taken back to the facility. Contact was made with Staff B, who was the only person in charge of 21 residents. She did not seem to be upset that the resident had left their secure facility and had been missing. Staff B stated there were people working in the building and that mush have been when he left. She also stated she did not know he was gone as he usually locked his door. Staff B stated her shift started at 7 PM and there were usually two people at the facility, not one.

The resident had mobility issues and did not walk very fast. He was found one mile from the facility and it was believed he was gone around 30 minutes to an hour before being in contact with law enforcement. The resident was returned to the facility at 8:18 PM, and at no time did they realize he was missing until being notified by the family member who spoke with him.

Interview with the assist administrator on [redacted] at approximately 11:45 AM who stated the resident was at risk of elopement and was not at risk anymore. She stated he did not have elopement identification on his person.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on record review and interview the facility failed to ensure an adverse incident report was submitted within one business day when a resident with [redacted] eloped from the facility for 1 of 3 sampled residents (#1).

Findings:

The Agency for Healthcare Administration received information that resident #1 eloped from the facility on [redacted]

Resident record review resident #1 revealed and Assisted Living Facility Health Assessment Form (1823) updated on [redacted] that indicated diagnoses of [redacted] and stated the "patient wanders". Review of the 1823 dated [redacted] indicated [redacted] due to acute [redacted] calm, [redacted] and not combative. The resident needed supervision with all activities of daily living and stated the resident was very "forgetful and patient wanders around".

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Review of facility notes revealed:

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Interview with Staff B, caregiver on ..... at 2:05 PM who stated at around 7:30 PM she looked around to check the residents. She noticed that resident #1 was gone. At 7:30 PM, the phone rang; it was resident #1's family member who called. The family member asked her if I she knew that resident #1 was with that family member. The family member stated the police called him to let him know that resident #1 was not at the facility, he was with the police officer. The police brought the resident back to the facility. The resident was gone from around 7 PM. He was ok when he got back. He did not wander or exit seek anymore. Sometimes he was ..... When he got back to the facility, he said he just walked and he was looking for his family member. The family member lived close by the facility.

Phone interview with family member on ..... at 12:20 PM who stated the resident had ..... He further stated a man was doing work on the facility and left the front door open. The resident walked over a mile, to State Road 436 (a busy multi-lane highway). He was gone longer than 30 minutes. He called the facility to let them know the resident was gone, and told them the resident was at his house with the police. The facility was not aware. He was out at least an hour, he was a slow walker. The resident knew the family member's name, so the police ran his name and they found him.

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resident said he no longer lived there. The family member's address was located and the resident was taken to his residence. Upon our arrival there I spoke with the family member who stated the resident suffered from [redacted] and he lived in Greeenbriar Retirement home. The family member was very alarmed the resident had wandered out and they had not received a call from the facility letting them know he was missing.

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The resident had mobility issues and did not walk very fast. He was found one mile from the facility and it was believed he was gone around 30 minutes to an hour before being in contact with law enforcement. The resident was returned to the facility at 8:18 PM, and at no time did they realize he was missing until being notified by the family member who spoke with him.

Review of adverse incident reports revealed there was no documentation to indicate the report was completed as required.

Interview with the assistant administrator on [redacted] at approximately 3 PM who stated she was unable to locate the adverse incident report.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Greenbriar Retirement
3615 McNeil Road
Apopka, FL 32703

Dear Administrator:

Re: CCR #2013012438

This letter reports the findings of a complaint investigation licensure survey that was conducted on 2014 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **, 2014,** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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

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Phone (407) 420-2502; Fax (407) 245-0998