STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969052	12/30/2016
NAME OF PROVIDER OR SUPPLIER **DISCOVERY VILLAGE AT PALM BEACH GARDENS**	STREET ADDRESS, CITY, STATE, ZIP CODE **100 DISCOVERY WAY** **PALM BEACH GARDENS, FL 33418**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced licensure complaint survey, CCR# 2016014082 , was conducted on 12/13/16 and concluded on 12/30/2016 at Discovery Village at Palm Beach Gardens, License #12883 . The facility had deficiencies at the time of the investigation.

This survey was cnducted in conjunction with the Change of Ownership survey conducted on the same date. See separate report for findings.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record reviews and interviews, the assisted living facility (ALF) failed to provide appropriate supervision to a resident residing in the secured unit, for 1 out of 3 sampled residents. As evidenced of Resident # 3's attempt to elope from the facility and experiencing a with injury to the resident's eye and lip.

implementation of interventions to meet a resident ' s needs (Resident # 3) as the resident displayed exit seeking behavior in the facility's secured memory care unit

The findings included:

Record review revealed Resident # 3 was admitted to the facility on . The ALF nursing admission assessment dated indicated that Resident # 3 is friendly, pleasant, alert but . Resident # 3 is easily understood and does not require any mobility assistance. Review of Resident #3's Health Assessment Form (AHCA Form 1823) dated documented the following diagnosis: , , nail biting and . Further review of the AHCA form 1823 documented that Resident # 3 is independent with ambulation, toileting and transferring. Resident # 3 was admitted into the facility's locked memory care unit.

A review of the facility's Incident Reports revealed an incident involving resident Resident #3 on , the following was documented. Resident # 3 tried to escape the facility and was found outside on facility grounds trying to get back inside the facility. Resident # 3 stated she was trying to look for her husband. Resident # 3 escaped through an unsecured window in an unlocked laundry the memory care unit. Staff members in the memory care unit were doing laundry and left the laundry unlocked. Upon investigation and observations, Resident # 3 as she climbed out of the unsecured window where she obtained a laceration to her lip and eye. Resident # 3 was found on facility

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grounds trying to get back into the facility. Staff C called 911, notified Resident # 3 ' s spouse and physician. Resident # 3 was sent to the hospital emergency evaluation.

During an interview with Staff C on at 5PM, the following was revealed. During the evening shift of , Resident # 3 was and looking for her husband. Staff C stated " we tried to distract her with activities, but she did not want to participate. She stated, she wanted to lay down, so Staff G got her ready for bed. " Staff C stated they kept an eye on Resident # 3 every 30 minutes because Resident # 3 kept wanting to look for her husband. At 9:30 PM Staff G noticed the Resident # 3 was missing. Staff G reported it and they went looking throughout the facility for the resident. They went outside and found Resident # 3 trying to come back in through an entrance of the Memory Care unit. Staff C noticed that Resident # 3 had a and on her face; Resident # 3 was not able to explain if she or where or how she obtained to her face. Resident # 3 was not observed with any signs of or prior to the last at 9 PM. Staff C stated they found Resident # 3 at 10 PM, assessed her and sent her out to the hospital, notified the physician and Resident # 3's spouse. Staff C stated Resident # 3 returned to the facility the next day in the morning.

During a interview with Staff G on / at 6:15 PM, the following was revealed. On during her shift in the memory care unit Resident # 3 was displaying exit seeking behavior and was asking for her husband. Staff G stated that she was working with 2 other staff members, Staff C and Staff H. Staff G stated they were all conducting on Resident # 3 every 30 minutes and more on that shift because of the residents' exit seeking behavior that evening. Resident # 3 kept wandering around and checking doors to get out. Staff G stated they tried to re-direct Resident # 3 and encourage activity but Resident # 3 kept asking for her husband until she decided to go to bed at 9 PM. Staff G and Staff H was doing laundry that shift and Staff G stated between the two of them the laundry door was left unlocked in between rounds. Staff G stated she knows that the laundry door is supposed to be locked and secured if a staff member is not in the laundry she assumed it must have been an oversight by staff. Staff G stated the window in the laundry shut down but not locked and Resident # 3 was able to open it and escape. Staff G stated when she went to check on Resident # 3 again at 9:30 PM on , Resident # 3 was missing. Staff G stated all staff members went looking for Resident # 3 and they noticed that the door and window in the laundry open. Staff G stated they found Resident # 3 outside of the memory care unit trying to come in. Staff G stated they found the resident with a around her eye and lip and she was assessed and sent to the hospital.

During an interview with Staff H on at 6:41 PM, the following was revealed. Resident # 3 was able to escape through the window in the laundry . Staff H stated that staff were doing laundry and forgot to lock the laundry . Staff H stated they were conducting frequent checks on Resident # 3 because she was wandering and kept asking for her husband. Staff H stated they found Resident # 3

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outside of the facility trying to get back inside. Staff H stated she does not recall the exact time the event occurred but she can remember that Resident # 3 was found within a few minutes of staff noticing that she was missing from her .

On and the facility's Director of Nursing and Director of Memory Care stated they are unable to identify which staff member in the memory care (MC) unit on the evening shift on was doing laundry and left the laundry unlocked.

A review of the facility's Elopement Policy and Procedure states the following: The priority of this community is to foster and environment of safety and good quality of life for all residents as much as possible. Although the resident may travel independently in the community, the assisted living staff is responsible for knowing the whereabouts of all residents.

During interviews with the Director of Nursing, Director of Memory Care and staff members on and , it was revealed that prior to the incident and at the time of the incident on , the facility did not implement a lockable handset to the MC laundry door, did not have a stop installed on the window from the MC laundry the exterior preventing it from opening, and did not have a policy on securing windows and doors in the Secured Unit until after the incident occurred.

On , at 3 PM, the Administrator, Director of Nursing, and the Director of Memory Care acknowledged the findings.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2017

Administrator
Discovery Village At Palm Beach Gardens
100 Discovery Way
Palm Beach Gardens, FL 33418

RE: CCR #2016014082

Dear Administrator:

This letter reports the findings of a state complaint survey that was conducted on , 2016 and concluded on , 2016 by a representative 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2017.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

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