STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969035	**10/17/2017**
NAME OF PROVIDER OR SUPPLIER **RIVERVIEW SENIOR RESORT**	STREET ADDRESS, CITY, STATE, ZIP CODE **3490 GRAN AVE** **PALM BAY, FL 32905**	

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

0000 - Initial Comments

A complaint investigation (2017007919) was conducted on , 2017. Riverview Senior Resort, license #12862, had deficiencies at the time of the investigation.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record reviews and interview, the facility failed to ensure an admission health assessment form 1823 was completed by a health care provider within 60 days before admission or within 30 calendar days of admission to the facility for 1 of 5 sampled residents (#1).

Findings:

Record review for resident #1 revealed an admission health assessment form 1823. The completion date on the form was indiscernible.

The form was signed by a health care provider however, the section on the form regarding how much assistance he required with handling personal and financial affairs the answers indicated "I help with calling for house repairs" and "I do all bills, he gets stressed over money" which was indicative that someone other than a health care provider completed the form.

During an interview with the director of clinical services on at 12:25 pm, she said the daughter of resident #1 completed the 1823.

Class III

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

Based on observations, record reviews, and interviews, the facility failed to provide adequate supervision for 2 of 3 residents (#1 and #5) who resided on a secured memory care unit.

Findings:

Observations made during a tour of the facility on at 9:30 am revealed the fourth floor unit was secured with a keypad code and could not be accessed in or out of the unit without the correct code. There was a push button bell on the outside wall and a window in the entrance door. Upon ringing, the bell to request entrance into the unit, observations made through the window revealed a man entered a code into the inside key , and opened the door. The staff identified him as resident #6.

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1. Record review for resident #1 revealed he was admitted to the facility on with diagnoses of , progressive and .

A note dated on indicated that his was progressive and he would need to be in a supervised living facility with no further driving.

A resident note dated on indicated that on the 3 pm-11 pm shift, he had a nighttime caregiver sitting out in the hallway by his . The night before he tried to get out of the door by repeatedly opening and closing it.

An adverse incident report dated on indicated that on at 10:25 am, his private sitter was unable to locate him. The community was searched. The police were called and he was located approximately 3 miles north of the community walking along Route 1. His family and health care provider were notified. He was moved to a the 4th floor secured memory care unit.

When questioned further on at 1:41 pm, the director of health services said when his private sitter went to use the , resident #1 left the unit.

On at 2:16 pm, he went into the medication , times and yelled at the nurse that he wanted to leave. Redirection was ineffective.

On at 3:47 pm, he was exit seeking and stated, "I want to go home." He voiced to the 7 am-3 pm shift that he wanted to "put a gun" to his head and kill himself. His daughter, a health care provider, and the memory care director were notified. His daughter reported that he said that type of thing even when he was at home.

An adverse incident report indicated that on , he and another resident were allowed to exit the secured memory care unit by an unknown individual. The men were observed to be down in the lobby by the concierge. The concierge asked them to stop but they continued into the parking lot. The concierge called out to nearby care associates who then went out and attempted to redirect the residents back into the community. The redirection was unsuccessful so the sales and marketing manager called to request assistance from the police department. The men continued down Gran Avenue and across Route 1 into the driveway of an apartment , . The caregivers were with the residents the entire time. Resident #1 picked up branches and stones and tried to hit the staff members with the items. He took off his belt and attempted to make a sling shot. Because of the incident, a private sitter was assigned to him.

2. Record review for resident #5 revealed he was admitted to the facility on with diagnoses of

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, and . He resided on the 4th floor secured memory unit.

An adverse incident report indicated that on , he and another resident were allowed to exit the secured memory care unit by an unknown individual. The men were observed to be down in the lobby by the concierge. The concierge asked them to stop but they continued into the parking lot. The concierge called out to nearby care associates who then went out and attempted to redirect the residents back into the community. The redirection was unsuccessful so the sales and marketing manager called to request assistance from the police department. The men continued down Gran Avenue and across Route 1 into the driveway of an apartment , . The caregivers were with the residents the entire time. His family and a health care provider were notified.

During an interview with the administrator on at 4 pm, he said resident #6 had the keypad code to the 4th floor unit because he was an independent resident who only lived on the unit because his wife lived there. He said resident #6 should not have used the code to open the door and allow visitors onto the unit. In addition, he said the first private sitter for resident #1 was stopped when he was moved to the secured unit on .

Upon ringing the bell to be allowed entrance into the 4th floor secured unit on at 4:50 pm, resident #6 again entered, a code into the inside key , and opened the door.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record reviews and interview, the facility failed to ensure 1 of 3 staff (A) received in-service training regarding the facility's resident elopement response policies and procedures within 30 days of employment.

Findings:

Personnel record review for staff A, a caregiver, revealed a hire date of . The record did not contain documented evidence to indicate staff A received in-service training regarding the facility's elopement response policies and procedures within 30 days of employment, as required.

On at 4:37 pm, the business office manager confirmed the finding.

Class III

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