STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968417	11/20/2017
NAME OF PROVIDER OR SUPPLIER **TRANQUILITY HAVEN**	STREET ADDRESS, CITY, STATE, ZIP CODE **3340 PINE ST** **COCOA, FL 32926**	

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

0000 - Initial Comments

Complaint Investigation #2017009464 was conducted on . Tranquility Haven, License #12299, had deficiencies at the time of the visit.

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

Based on the Agency for Health Care Administration's (AHCA) adverse incident report, facility's incident report, Department of Children Families (DCF) notification, resident record reviews and interview, the facility failed to provide appropriate supervision as required for all the residents who require assistance with activities of daily living (ADLs), and failed to maintain awareness and whereabouts of 1 of 7 residents who eloped from the facility (#7).

Findings:

On at 4:05 PM, the facility's incident report revealed that resident #7 eloped from the facility. The remaining 5 residents were left unsupervised while unlicensed caregiver staff D went out of the facility searching the whereabouts of resident #7.

On at 4:21 PM, the AHCA adverse incident report was filed and revealed that caregiver staff D was responsible for immediate care of the residents in the facility, and that staff D left the facility, leaving 5 residents alone for 30 minutes. Furthermore, documentation revealed that a neighbor who lived 1 away called local law enforcement (Sheriff's department) was called to locate resident #7.

On , DCF notified AHCA of the elopement of resident #7 and conducted their own investigation.

Resident #1's record review revealed diagnosis of 's , severe memory loss, and high risk, and requires assistance with dressing, eating, & toileting, supervision with transferring, and total care with bathing with ADLs.

Resident #2's record review revealed diagnosis of , was wheelchair bound, and requires assistance with dressing, , and bathing; supervision toileting and transferring with activities of daily living (ADLs).

Resident #3's record review revealed diagnosis of with behavior disturbance, high risk, and requires assistance with ambulation, bathing, eating and , total care with dressing, toileting, and transferring with ADLs.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968417	11/20/2017
NAME OF PROVIDER OR SUPPLIER **TRANQUILITY HAVEN**	STREET ADDRESS, CITY, STATE, ZIP CODE **3340 PINE ST** **COCOA, FL 32926**	

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

Resident #4's record review revealed the resident was receiving hospice care and needed total assistance with all ADLs.

Resident #5's record review revealed diagnosis of , , failure, , was wheelchair bound, and requires assistance with all ADLs except independent with eating.

Resident #6's record review revealed the resident was receiving hospice care and needed total assistance with all ADLs.

Resident #7's record review revealed an admission on for respite care, a diagnosis of , and requires supervision with all ADLs.

On at 3:30 PM, a telephone interview was attempted with staff D, but there was no response and no returned call back from staff D after voicemail message was left.

On at 4 PM, the administrator confirmed the findings.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on the facility's elopement policies and procedures, AHCA agency's adverse incident report, resident record review, personnel record review and interview, the facility failed to follow protocol of the elopement policies and procedure as required for a missing resident, and failed to maintain awareness and whereabouts of 1 of 7 residents who eloped from the facility (#7).

Findings:

The facility's elopement policy and procedures reflects that when it is determined that a resident is missing from the facility, the following should be done immediately below:
A. verify sign out log to see if resident has signed out;
B. Check with all staff (not applicable as staff D was the only caregiver staff working during elopement);
C. Notify the Administrator/Owner;
D. Immediately conduct a thorough search of the entire facility and ground. If resident is not located within 10 minutes or less, notify and call 911.
Caregiver staff D failed to follow all of the facility's policy and procedure.

On at 4:05 PM, caregiver staff D did not know the whereabouts of resident #7 for 30 minutes.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968417	**11/20/2017**
NAME OF PROVIDER OR SUPPLIER **TRANQUILITY HAVEN**	STREET ADDRESS, CITY, STATE, ZIP CODE **3340 PINE ST** **COCOA, FL 32926**	

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

Staff D left the remaining 5 residents in the facility alone while she went outside the facility searching for the resident. A neighbor who lives 1 . . . away found resident #7 and called law enforcement to return the resident back to the facility.

On at 4:21 PM, the Agency for Health Care Administration's adverse incident report was filed and revealed that caregiver staff D was responsible for immediate care of the residents in the facility, and that caregiver staff D left the facility, leaving the 5 other residents in the facility alone for 30 minutes. Furthermore, documentation revealed the neighbor who lived 1 . . . away called local law enforcement (Sheriff's department) was called to locate resident #7.

Staff D's personnel record review revealed a hire date of , completed the elopement response training on . . . , and completed a facility's last elopement drill on . . .

Resident #7's record review revealed admission for respite care on . . . with a diagnosis of , and needing supervision with all Activities of Daily Living (ADLs).

On at 4 PM, the administrator confirmed the findings.

Class II