STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966084	**06/11/2018**
NAME OF PROVIDER OR SUPPLIER **TITUSVILLE TOWERS**	STREET ADDRESS, CITY, STATE, ZIP CODE **405 INDIAN RIVER AVENUE** **TITUSVILLE, FL 32796**	

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

0000 - Initial Comments

A Complaint Investigation #2018004082 was conducted on and . Titusville Towers, License #10346, had a deficiency at the time of the visit.

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

Based on record reviews and interviews, the facility failed to follow its elopement policy and procedure.

Findings:

The Agency received a complaint that a resident whereabouts were unknown and the facility staff were not aware where the resident was.

On at 10:19 a.m., caregiver A said that on at 8 a.m., she went upstairs to give resident #8 her medications. The resident was not there so she believed the resident was downstairs. She continued with her medication pass and at approximately 8:45 a.m., she went downstairs. She did not see the resident downstairs, so she went to the resident's . When she did not find the resident in her , she immediately went back downstairs and asked other staff whether any of them had seen the resident. She said the facility's elopement procedure was initiated, the resident's family was called, and all staff were looking for the resident. She said she was on an upstairs balcony when she observed police officers go to an area by the river, which was where resident #8 was located. She said three caregivers and social worker H assisted during the search of the resident on .

On at 10:30 a.m., dietary staff C said she worked on when resident #8 was missing, and said on at 9:30 a.m., a facility nurse entered the kitchen and asked whether the resident was seen during breakfast. She said there was no additional information provided by the nurse to indicate the resident was missing and a search needed to be conducted. A half hour later, she and dietary staff G went outside for a break and she observed a police officer run toward an area off of the river where the resident was located. She said she and dietary staff G also ran to that location and she saw the resident lying on the ground by the water.

During a phone interview with caregiver D on at 12:45 p.m., she said on at approximately 1:30 a.m., resident #8 came downstairs with her walker and said she was hungry. She had no food to give the resident so she instructed the resident to return to her check her own kitchen for some food. At approximately 2:30 a.m., she observed the resident downstairs and the resident said she was unable to sleep. At approximately 5:15 a.m., she observed the resident

downstairs, and the resident asked about breakfast. Caregiver D told the resident it was not long before breakfast time, and told the resident she could wait in the lobby until breakfast. Caregiver D said it was the first time she ever observed the resident come downstairs like she had on that night.

An adverse report, submitted by the facility and dated , indicated that resident #8 was observed by caregiver D on at approximately 2:30 a.m., 3 a.m., and finally at 5:15 a.m. When caregiver D returned downstairs on at 6 a.m., resident #8 was no longer in the lobby. In addition, the report indicated that when caregiver A informed social worker H at 8:45 a.m. that the resident could not be located, two other nursing staff assisted caregiver A in the search. It was not until after law enforcement was notified at 10:09 a.m. that dietary staff were involved in the search. The resident was found lying on the sand next to the embankment by a police officer and dietary staff C at 10:14 a.m.

During a phone interview with dietary staff G on at 3:45 p.m., she said on at 9:30 a.m., a caregiver entered the kitchen and asked whether anyone had seen resident #8. She said she was not instructed to conduct a search for the resident. At a later time, she went on a break with dietary staff C and she observed the police running across the sea wall. She and dietary staff C ran over to the location and she observed resident #8 laying on the sand next to the river. She said had the kitchen staff been notified to conduct a search for resident #8, she would have searched that area because that was the area assigned to the kitchen staff.

During a phone interview with social worker H on at 4:24 p.m., she said that on between 9:15 a.m. and 9:30 a.m., caregiver A approached her and reported that resident #8 could not be located. Caregiver A searched , then she and caregiver A left messages for the resident's family, looked around outside, and then at 10 a.m., she called the facility manager who instructed her to call law enforcement.

Resident #8's record indicated she was admitted to the facility on . A health assessment form 1823, dated on indicated her diagnoses included , , history of a , , , , , , and .

The facility's elopement policy and procedure indicated that when facility staff believed a resident elopement may have occurred, staff would immediately notify the facility manager or designee. If an initial search was unsuccessful, the facility manager or designee shall delegate responsibility, commencing a speedy search of the facility premises. Upon completion of a search of the facility and grounds the resident's family, guardian, healthcare surrogate, case manager, and with approval of the facility manager, local authorities and physicians would be notified of the possible elopement.

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Caregiver A first reported that she could not locate the resident at 8:45 a m. However, law enforcement was not contacted to aid in the search until 10:09 a.m. When questioned further on at 4 p.m., the facility manager said she was not called by social worker H until 10 a.m., and it was at that time that she instructed the staff to contact law enforcement. The manager said caregiver A should have called her as soon as resident #8 could not be located.

Review of hospital records on at 2:40 p.m. revealed resident #8 was admitted to the hospital on . A history and physical, dated on , indicated she over a sea wall and ribs two through eight. A hospital discharge summary, dated on , indicated she also sustained a left .

Review of the facility's admission and discharge log indicated the resident was discharged to the hospital on due to a decline in her health and mental status.

Class II