STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965844	10/22/2018
NAME OF PROVIDER OR SUPPLIER **FRESH HORIZON'S ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **4836 35TH AVENUE** **VERO BEACH, FL 32967**	

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR# 2018010672, was conducted on at Fresh Horizon's Assisted Living Facility, License # 10323. The facility had deficiencies at the time of the survey.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, it was determined that the facility failed to ensure that a Resident was reassessed for continued residency based on displaying signs of , and significant behavior changes to ensure that the facility could meet the resident's needs, for 1 out of 3 sampled residents (Resident #1).

The findings include:

Review of police records revealed Resident #1 eloped from the facility on . Resident #1 was found by local law enforcement and determined to have based on behavior; resident transfered to local hospital. Resident#1 was later returned to the facility on the same date after determining the resident's home (ALF facility determined). Further interview with the Administrator on at 10:45 AM, revealed Resident #1 was under the supervision of Staff A. It was determined that Staff A forgot to lock the gate; she asleep; and failed to follow protocol for elopement procedures.

Review of Resident #1's Health Assessment dated a few months prior to the elopement incident revealed no evidence of the resident's , and elopement risk. It was determined that the facility failed to obtain a new Health Assessment based on the resident's elopement and diagnosis of and as of the incident.

Class III

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

Based on interview and record review, it was determined the facility failed to maintain a general awareness of each resident's whereabouts, for 1 of 3 sampled residents (Resident #1).

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FRESH HORIZON'S ASSISTED LIVING FACILITY	**4836 35TH AVENUE VERO BEACH, FL 32967**

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

The findings include:

During interview and record review conducted with the Administrator, on beginning at approximately 10:45 AM, the Law Enforcement (Sheriff's Department) narrative showed the following. On at approximately 0225 hours, Resident #1 was attempting to enter an apartment (and was knocking on door) on 38th Circle. Officers responding questioned Resident #1 and they decided he had . Resident #1 was transported to local hospital emergency the emergency advised Law Enforcement that this individual's last known address was Fresh Horizon's Assisted Living Facility. Officers made contact with Staff A and she confirmed Resident #1 resided at that location. Resident #1 was transported back to facility and was released to Staff A. Staff A stated she last saw Resident #1 at 0100 hours and that she did not know he was gone until contact with law enforcement.

During interview and record review conducted with the Administrator, on beginning at approximately 10:45 AM, the following was noted. The Adverse Incident Report that was filed by the Administrator was dated (16 days after the elopement incident). This Adverse Incident Report reflected Resident #1 had eloped from the facility on and that Staff A was on duty at that time. The narrative indicated on at approximately 0225 hours, Resident #1 was attempting to enter an apartment (and was knocking on door) on 38th Circle. Officers responding questioned Resident #1 and they decided he had . Resident #1 was transported to local hospital emergency the staff advised them that this individual's last known address was Fresh Horizon's Assisted Living Facility. Officers made contact with Staff A and she confirmed Resident #1 resided at that location. Resident #1 was transported back to facility and was released to Staff A. Staff A stated she last saw Resident #1 at 0100 hours and that she did not know he was gone until contact with law enforcement. Staff A stated she forgot to lock the gate; she asleep; and failed to follow protocol for elopement procedures.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interview and record review, it was determined the facility failed to report within 1 business day after the occurrence of an adverse incident, a preliminary report to the agency for 1 of 3 sampled residents (Resident #1).

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FRESH HORIZON'S ASSISTED LIVING FACILITY	**4836 35TH AVENUE VERO BEACH, FL 32967**

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

The findings include:

During interview and record review conducted with the Administrator, on beginning at approximately 10:45 AM, the Adverse Incident Report that was filed by the Administrator was dated (16 days after the elopement incident). This Adverse Incident Report reflected Resident #1 had eloped from the facility on and that Staff A was on duty at that time. The narrative indicated on at approximately 0225 hours, Resident #1 was attempting to enter an apartment (and was knocking on door) on 38th Circle. Officers responding questioned Resident #1 and they decided he had . Resident #1 was transported to local hospital emergency the staff advised them that this individual's last known address was Fresh Horizon's Assisted Living Facility. Officers made contact with Staff A and she confirmed Resident #1 resided at that location. Resident #1 was transported back to facility and was released to Staff A. Staff A stated she last saw Resident #1 at 0100 hours and that she did not know he was gone until contact with law enforcement. Staff A stated she forgot to lock the gate; she asleep; and failed to follow protocol for elopement procedures.

During interview and record review conducted with the Administrator, on beginning at approximately 10:45 AM, she was asked why it took so long (16 days) to file the Adverse Incident Report. She stated she was not made aware of the elopement until {Agency name} came in to investigate. She was not sure of that date. She stated Staff A never informed anyone of the elopement per facility protocol.

This surveyor made contact with the {Agency name } investigator's office, on at approximately 8:45 AM, and was informed this inspection occurred on at 12:00 PM when Staff A was interviewed related to Resident #1's elopement and an interview with the Administrator was conducted on at approximately 3:00 PM.

Class III