Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968651	A. BUILDING: _____ B. WING _____	C 09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANES VIEW LODGE	1601 HOOKS ST CLERMONT, FL 34711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaints numbers 2019010792, 2019011772, and 2019014116) and Emergency Power Plan (EPP) monitoring survey was conducted at Cranes View Lodge on , through , . Deficient practice was identified at the time of the survey.	A 000		
A 025 SS=J	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident.	A 025		

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A 025	Continued From page 1 (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to provide personal supervision appropriate for the needs of the residents for 1 of 15 sampled residents, Resident #1 out of a total of 122 residents. Findings: Review of Resident #1's Medication Observation Record (MOR) for the month of [redacted] revealed Resident #1's 4:00 PM medication on [redacted] was not provided. Documentation on the MOR read "Out of building" as denoted by Staff C, Medication Technician (MT). Review of the MOR for [redacted] at 8:00 AM revealed Resident #1's 8:00 AM medication was not provided. Documented on the MOR was "Out of building" as denoted by Staff B, MT. Review of the facility's Resident Sign Out Log revealed Resident #1 had been signed out of the	A 025		

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A 025	Continued From page 2 facility on . . . . . at 12:30 PM and was signed into the facility at 1:45 PM. There was no documentation after 1:45 PM on of Resident #1 having signed out on the facility log. Review of Resident #1's records revealed there was no documentation of Resident #1 having attended the evening meal on . . . . . or the breakfast meal on . During an interview on at 9:45 AM the Executive Director (ED) she stated, [Resident #1's name] is known to sit at the same table and in the same seat for all of his meals. During an interview on . . . . . at 2:00 PM via telephone Staff C, MT stated, " On around 4:30 PM I went to [Resident #1's name's] room to assist him with self administration of medication and he wasn't there. I looked in the dining room right after for [Resident #1's name] and he wasn't there." When asked if she reported not being able to locate Resident #1, Staff C stated, "No, I just marked him out of the building on the MOR. Staff C verified she did not attempt to locate the Resident per the missing resident procedure. Staff C then stated, "Between 7:00 PM and 7:45 PM I checked to see if [Resident #1's name] had come to his room, but he still wasn't there." When asked if this was reported Staff C stated, "No." During an interview on at 2:20 PM Staff B, MT stated, "On . . . . . at 8:15 AM, [Resident #1's name] was not in the room when I went to assist with self-administration of medication. I went downstairs to check if [Resident #1's name] was in the dining room, but he was not. I then checked the sign out book and	A 025		

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A 025	Continued From page 3 noted he had not signed as being out of the facility. On from 8:15 AM to 9:30 AM, I completed assisting other residents with self-administration of medication. At 9:30 AM, I went to check to see if [Resident #1's name] had returned to his room, but he was not in the room. I then reported it to [Staff A, LPN's name]. On at 9:30 AM [Staff A, LPN's name] initiated the facility's missing residents procedure. On at 9:30 AM, the Assistant Resident Services Director contacted the family to ask if the resident was with family and a search was started of the entire facility, including the roof and grounds. [Resident #1's name] was not found in the facility and was reported to not be with family. On at 10:19 AM, the Maintenance Director took pictures of [Resident #1's name] to local businesses and to the construction site across the street to determine if they had seen the resident and conducted a search of the , but Resident #1 was not found. Record review of the facility's Missing Resident Search Report dated at 4:00 PM revealed on at 9:30 AM, Resident #1 was reported as missing to the Executive Director. After an internal search of the building and surrounding local stores and area, at 11:19 AM the Executive Director notified local law enforcement of Resident #1 being missing. On at 11:20 AM local Police Department Officer (PDO) arrived at the facility. Review of the facility's policy and procedure titled, "Assisted Living Missing Resident (Elopement) Policy- FL" effective date read: "When Community associates determines that a resident of the Community cannot be accounted for or immediately located, they are "Missing.	A 025		

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A 025	Continued From page 4 Should the resident search not prove to be successful within approximately one (1) hour from the time the resident is determined to be missing; the (Resident Services Director) shall take all reasonable efforts to: 1. Notify the ED (Executive Director) if not already notified, 2. Notify the family, 3. Notify the Police Department." Record review of Resident #1's health assessment (AHCA Form 1823), (Agency For Healthcare Administration) dated revealed "Medical History and Diagnoses: Type II, Visual . Physical or Sensory Limitations: Poor balance, limited mobility. or Behavioral Status: Poor memory, and pleasant (sic). Special Precautions: Precautions. Section B-General Oversight indicated daily oversight for Observing Wellbeing, Observing Whereabouts and Reminders for Important Tasks Sections." Review of Resident #1's Assisted Living Functional Needs Evaluation dated read: "Cognition: Was a mini-Cog ( ) and/or CAM (Assessment Method) Evaluation completed? No. Bathing, Grooming, and Eating: Type of Assistance: Reminders." Review of the Staff C's job description titled, "Care Staff" dated read: "Report all observations to the Resident Services Director and Assistant Resident Services Director. During an observation of the security camera video on at 3:04 PM Resident #1 can be observed exiting the elevator and walking towards the two entrances of a common living area. At the of the common living area	A 025		

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A 025	Continued From page 5 there is a screen porch. The video was observed until the time stamp of 11:20 AM on , the time of the police officer arrival. Resident #1 was not observed on video again for the time frame of . . . . . at 3:05 PM to 11:20 AM on . During an interview on at 3:09 PM, with the Executive Director (ED), a request was made for the facility policy and procedure for supervision. No policy and procedure were provided. The ED stated: "I would expect my staff to follow the resident's individualized care assessment. The level of supervision for each resident is determined by the individualized service plan which is updated quarterly or with a significant change." The ED confirmed from at 7:45 PM until at 8:15 AM no observations of [Resident #1's name] were attempted. Review of the Supplement Report completed by the local Police Department Detective dated at 9:52 AM read: "The Officer reviewed the facility's camera videos. On at 11:36 AM, the local Police Department Officer (PDO) contacted the area hospitals, the resident was not located. Businesses were checked and the resident was not found. On at 1:02 PDO canines, drones, and E1 helicopter on scene. A patrol car was dispatched to [Resident #1's name] last address. [Resident #1's name] was not at his former address. On at 2:08 PM [Resident #1's name] was observed by the helicopter. On at 2:15 PM PDO arrived at the scene and found [Resident #1's name] lying in the high grass on the south side of the street behind a local business. The Officer on the scene indicated [Resident #1's name] was	A 025		

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A 025	Continued From page 6 . . . . . which was confirmed by the fire department and (Emergency Medical Service). I did a visual of the scene and observed the following: [Resident #1's name] was on his . . in an area that looked like a nest, which appeared [Resident #1's name] could not get up and had been rolling around. Approximately 10 ft ( ) from him was his sunglasses and in his . . was his reading glasses. [Resident #1's name] was observed to have . . . . . to the front and . . of his . . . He was wearing the same clothes described by the daughter on . . . . . On . . . . . at 9:30 AM an autopsy of [Resident #1's name] was conducted. Detective from the local Police Department was present, and he reported: "The . . . . . to [Resident #1's name] . . . were superficial due to there being no . . . . . hematoma visible. [Resident #1's name] was found to have several throughout his body, but it appeared from the preliminary examination the cause of was ." Class I	A 025		