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
	AL11953584	A. BUILDING: _____ B. WING _____	04/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINS OF MELBOURNE	4451 STACK BLVD MELBOURNE, FL 32901

(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 Complaint Investigations #2022001418, #2022002862 and an [illegible] Control Monitoring were conducted on [illegible]. Fountains of Melbourne had a deficiency at the time of the visit.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [illegible] or [illegible] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [illegible] or [illegible]. 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 must notify the resident's representative or designee of the need for health care services and must assist in making [illegible] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. 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	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, 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. (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 reviews and interviews, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision to 1 of 4 sampled residents who eloped from the facility (#5). Findings: Resident #5's record revealed a facility admission date of . . . . . An 1823 health assessment form, dated , indicated the resident's diagnoses included 's . . . . . , , Degenerative Disc . . . ,	A 025		

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A 025	Continued From page 2 . . . . . , ... Valve . . . . . .; she had memory loss and was not an elopement risk. An admission note, dated , indicated the resident was alert and oriented to place only. On . . . . . at 12:35 p.m., a note indicated the resident had been up and . all night. On at approximately 6:30 p.m., a note indicated the front desk staff reported that a good samaritan called the facility and reported that the resident was found at a gas station located approximately one mile from the facility. Facility staff retrieved her from that location and returned her to the facility. A family member of the resident was asked to stay the night at the facility to ensure no further elopements occurred. The resident's physican was notified and no new orders were given. A facility incident report indicated that on at 4:59 a.m., a law enforcement officer notified the facility that he found the resident and took her to her family member's house. The family member who stayed overnight had asleep on the couch and did not hear the resident leave the room. The resident did not return to the facility and was moved to a secured facility. The note did not indicate where the resident was found by law enforcement. On . . .. at 12:08 p.m., nurse A said that on she learned the resident was found at a nearby gas station. The nurse asked the resident's family member to come to the facility and stay with the resident. The nurse said the resident was normally and oriented only to self and to her family. She said the resident had not verbalized the desire to leave that day	A 025		

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A 025	Continued From page 3 and the nurse had not seen the resident make any attempts to leave. The nurse's shift on that day was 7 a.m. to 7 p.m., and she could not remember the last time she saw the resident before the elopement. On at 12:42 p.m., maintenance staff B said he brought the resident from the gas station and said the resident was at the time and did not know where she was. On at 1:13 p.m., caregiver D, who worked the overnight shift, said the resident normally around the facility while carrying clothes and shoes. When she did, caregiver D said she walked the resident to her room. The caregiver said she would sit in the hallway or the nurse's station to look out for the resident. On at 3:07 p.m., caregiver E said that on she last saw the resident during the evening medication pass, which was approximately 8 p.m. The caregiver said the resident normally walked around the facility. On at 3:19 p.m., agency caregiver F said she frequently worked at the facility and was familiar with the resident. The caregiver said she usually sat on a hallway bench to look out for the resident. She said that on between approximately 10:30 p.m. and 11 p.m., she went into the resident's room to check on her and when she did, the resident's family member was there and said the caregiver did not need to come in and check anymore. The caregiver said after that, "I pretty much focused on everyone else." On at 3:50 p.m., the director of nursing (DON) said that after the resident eloped to the gas station, she discussed having a private aide	A 025		

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A 025	Continued From page 4 sit with the resident but, the family did not want to pay for one. The DON said that at the time of the second elopement, law enforcement found the resident on the road located in front of the facility. The DON said she spoke with staff following each elopement but was unable to determine how the resident got out of the facility. The facility's policy " /Missing Resident Plan", undated, read in part on page 2 B 3, "ALZ ( ) residents . . . exhibiting active exit seeking behaviors will have their service plan updated to reflect appropriate interventions, which may include. . . personal sitter for immediate (24/7) resident safety [and] monitoring of the resident's whereabouts . . . ." The facility asked a family to stay with the resident instead of providing 24/7 personal sitter to provide resident safety. The family member asleep, and the resident eloped again. Class II	A 025		