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
	AL11968567	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA LANDING	1279 HOUSTON ST MELBOURNE, FL 32935

(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 Investigation #2022006618 and Generator Monitoring was conducted on . Victoria Landing had deficiencies at the time of survey.	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 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 must notify the resident's representative or designee of the need for health care services and must assist in making 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 resident diets in accordance with Rule	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 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 observation, 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 for 2 of 3 sampled residents who eloped from the facility (#1 & #2). Findings: 1. Resident #1's record revealed the resident was [redacted] who was admitted to the facility's Memory Care Unit on [redacted]. An 1823 Resident Health Assessment (1823), dated [redacted], indicated his diagnoses included [redacted]	A 025		

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A 025	Continued From page 2 . . . . . , and . . . . . The 1823 revealed resident #1 was not an elopement risk; he was a . . risk, and was under hospice care. The 1823 revealed his needs could be met in an Assisted Living Facility. Resident #1's facility note, dated . . . . . at 6:45 AM, indicated resident #1 was found in the parking lot. 2. Resident #2's record revealed the resident was , who was admitted to the facility Memory Care Unit on . . . . . . An 1823, dated . . . . indicated her diagnoses included . . . . . , , , and . The 1823 revealed resident #2 was an elopement risk. Review of Special Precautions section of 1823 included resident . . . . . in the facility and tries to get out of unit. Further review revealed her needs could be met in assisted living facility. An 1823, dated , indicated resident #2 was not an elopement risk. A facility note in the record, dated at 6:45 AM, indicated resident #2 was seen opening a car door in the parking lot of a worker who had just arrived at the facility. On . . . . . at12:20 PM, the Administrator and Director of Nursing (DON) confirmed there was an event involving 2 memory care residents. Residents #1 and #2 who were found in the parking lot by staff D and staff E On . . . . . at 1:50 PM, the facility's video footage from the morning of showed resident #1 in a wheelchair in the hallway of the memory care unit. Resident #2 was noted walking . . . and forth in the hallway of the memory care unit. The video showed resident #1 pushing the	A 025		

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A 025	Continued From page 3	A 025		

exit door at 6:38 AM. He stood up from his wheelchair and pushed the door open, then sat down in his wheelchair. As resident #1 sat down, resident #2 walked unassisted through the door in front of resident #1. She proceeded to the second door, about 6 , and turned the lock to unlock it. Resident #2 exited the second door at 6:39 AM. Resident #1 followed resident #2 through the first door. At 6:40 AM, resident #1 exited the second door onto the sidewalk leading to the parking lot. At 6:42 AM, staff E pushed resident #1 in the wheelchair into the building through the same doors he had exited. At 6:43 AM, staff D escorted resident #2 into the building through the same doors she exited.

On at 1:55 PM, the Director of Nursing (DON) confirmed she found out about the residents exiting the secured memory care unit when staff D called her on at about 6:45 AM and told her resident #2 got in her car when she parked to come to work. DON said staff D also advised her that resident #1 was on the sidewalk ramp in the parking lot.

On 3:09 PM, staff C said, at the time of the incident involving resident #1 and #2 leaving the facility, she was in a resident's room on the other side of the memory care unit giving a shower. She said she could not hear the door alarm because she was giving a shower on the other side of the unit. She said she was alerted by staff B about the alarm going off. Staff C said when they got to the door that was alarming, the nurses were coming in and told them 2 residents had gotten out.

Review of the facility's investigation revealed it included staff written statements regarding resident #1 and #2's elopement from the memory

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A 025	Continued From page 4 care unit on . . . . . . Staff C's statement, dated , indicated wrote she was giving a resident a shower and she did not hear the alarm. Staff E's written statement, dated , indicated she arrived to work and observed resident #2 in the parking lot opening car doors. She also observed resident #1 at the bottom of the sidewalk ramp. She assisted residents into the facility. Staff D's written statement, dated . . . . . , indicated at around 6:45 AM, she arrived to work and when she parked, resident #2 got into her car and she observed resident #1 coming down the sidewalk. She assisted the residents . . . into facility. Staff B's written statement, dated , indicated she was in a resident's room completing ADL care. She did not hear the alarm. Staff F's undated written statement indicated that at approximately 6:50 AM, she was on the assisted living side of the building. She heard on the radio to come to memory care unit. She saw an agency nurse bringing residents into building. The facility's elopement policy revealed that "An elopement occurs when staff determines a resident is missing or whenever a resident leaves the secured confines of a Memory Care at Victoria Landing unattended by staff or family." On at 3:46 PM, the DON confirmed resident #1 and #2 eloped from the facility's secure memory care unit to the facility's parking lot on . . . . . at about 6:45 AM.	A 025		

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A 025	Continued From page 5 Photographic evidence was obtained. Class II	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo	A 032		

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A 032	Continued From page 6 identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to conduct and document a minimum of 2 resident elopement drills each year for 2 of 3 staff reviewed (B & C). Findings: On , a review of staff B's personnel file revealed she was hired on . Her file revealed she participated in one elopement drill	A 032		

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A 032	Continued From page 7 on . . . . . . On . . . . . , a review of staff C personnel file revealed she was hired on . Her file revealed she participated in one elopement drill on . On , TIME????, the Director of Nursing said she could not provide any further documentation of resident elopement drills. She confirmed staff B and C did not participate in 2 elopement drills in 2021. Class III	A 032		