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
	AL11965658	A. BUILDING: _____ B. WING _____	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM COTTAGES OF ROCKLEDGE	3821 SUNNYSIDE COURT ROCKLEDGE, FL 32955

(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 (#2024004646) and generator monitoring were conducted on at Palm Cottages of Rockledge. A deficiency was found 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 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 record reviews, observation and interviews, the facility failed to ensure the safety and awareness of 1 of 3 sampled residents at risk for elopement (#1). Findings: In a record review of resident#1, it revealed an admission date of and a health assessment dated . The resident's medical history included 's , hearing Loss, limited insight, word finding difficulty, of time and day, reminders for bathing and changing clothes, reminders for medication, forgetful of conversations. The	A 025		

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A 025	Continued From page 2 resident resided in the memory care unit and was an elopement risk. In a review of the facility's observation and investigation notes documented on . . . . . at 1:36am, a resident brought to facility by police due to eloping down the street at approximately .50 mile from facility. Camera footage observed the caregiver put a code in to open the door and watched the resident walk out of facility. The caregiver did not realize the resident lived at the facility and thought he was a visitor. No injuries occurred. Resident was seen 1 hour before incident occurred. The caregivers did not do an accurate . . . count before coming on shift at 11pm. Law Enforcement report dated identified an elderly white male at a 7 eleven who appeared lost. Officers went to multiple assisted living facilities to see where the resident eloped from. Caregivers at Palm Cottages were asked if they were missing the resident, they stated no. Then called the officers and stated he was missing from the facility. The caregivers stated the next check on the residents was at 0100 hours. The Department of Children and Families were notified. Resident was assessed after the elopement incident and found with no injury. Review of the incident report dated . . . . revealed at 11:23pm the resident was seen getting up from the couch in the facility and goes to the patio and attempts to get out of the memory care unit. He walked . . . to the caregiver and the caregiver and resident walked . . . to the patio and the caregiver put in the code to open the door and the resident exited. At 1:30am the resident was found by law enforcement at a convenience store .08 miles	A 025		

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A 025	Continued From page 3 from the facility and brought . . . to the facility. The caregiver, due to her lack of awareness regarding the resident's status as a resident of the community, thought he was a visitor and allowed the resident to exit. The caregiver was terminated. Review of the facility's elopement policy defined an elopement as when a resident leaves the facility without authorization according to facility policy and procedures. All employees will monitor residents for risk of elopement. If there is a concern that a resident is at risk, they will notify their supervisor. Residents will be placed in memory care. During an interview on at 11:15am with resident#1, stated he doesn't remember the incident and he likes living here now but sometimes he likes to see his home. He started the care staff are good to him and takes care of him but will not let him leave the facility. Interview on at 11:30am with caregiver A, stated around 10:55pm she noticed 2 people on the sofa in the facility a lady and a man who were watching a movie. About 15 to 20 minutes later the movie ended and another resident asked me to assist her to bed. When I was finished assisting the other resident, the man watching the movie stated he was finished and was heading home. I then proceeded to follow the man toward the exit door of the cottage. I believed him to be a visitor and let him out of the facility. The nurse realized he was missing and called the administrator. Law enforcement saw him down the road and brought him . . . . During an interview on at 1pm with caregiver E stated one of our her is to always do	A 025		

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A 025	Continued From page 4 2-hour checks on the residents. She stated resident#1 was new and the staff was not aware he was exit seeking. She stated, however, at that time of night I do not see how he was mistaken for a visitor. During an interview on . . . . . at 1:15pm with caregiver F stated she always does 2-hour checks on the residents and caregiver A should have realized resident#1 was not a visitor but a resident. She stated we have other residents that like to , and they have never eloped from the facility. Interview on . . . . . at 1:30pm with the nurse manager, stated that staff A was new and did not recognize that resident#1 was not a visitor and let him out of the building. She stated the resident was checked an hour prior to the incident. She stated the caregiver was terminated the next day. During an observation on at 10am, residents 1, 2 and 9 were wearing identification bracelets to include the resident's name address, and phone number. Interview on at 2pm with the nurse manager confirmed the findings. She stated the administrator was not in today, but she will advise her of the findings. Photographic evidence obtained Class II	A 025		