STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968567	01/07/2019
NAME OF PROVIDER OR SUPPLIER **VICTORIA LANDING**	STREET ADDRESS, CITY, STATE, ZIP CODE **1279 HOUSTON ST** **MELBOURNE, FL 32937**	

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

0000 - Initial Comments

A Complaint Investigation #2018014927 was conducted on . Victoria Landing, License #12434, had deficiencies at the time of the investigation.

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

Based on record reviews and interviews, the facility failed to provide adequate supervision and interventions when 1 of 3 residents eloped from the facility (#1), and when 1 of 3 residents experienced multiple (#2).

Findings:

1. A complaint was received by the Agency that indicated resident #1 went missing from the facility on at 2:30 a.m.

On at 12:23 p.m., caregiver B identified resident #1 and said she eloped from the facility on . Caregiver B worked the 11 p.m-7 a.m. shift that night, and reported the resident missing at 1 a.m. She said staff conduct 2-hour rounds on the residents at 11 p.m., 1 a.m., 3 a.m., and 5 a.m. The resident was gone at 11 p.m. but she did not think it was a concern at the time as she figured the resident was with her family. At 1 a.m. when the resident was still not seen, she checked the sign out book, checked the building for her, then she followed the elopement protocol. She said the next day the police returned the resident to the facility, and the resident was moved to the memory care unit.

On at 1:16 p.m., caregiver C said she was the resident's caregiver on the p.m. shift when she eloped on . She said resident checks were conducted every day at 2 p.m. and 9 p.m. However, on that night she conducted her 9 p.m. check on every room except the room of resident #1 because she got busy. She received a call from the facility at 1 a.m. asking whether she saw the resident. She believed she saw her last at dinner eating sherbet and drinking tea.

Resident #1's record revealed a facility admission date of . An initial 1823 health assessment form, dated , indicated she had decline, , and agitation at times. A more recent 1823, dated , indicated that she had , and was an elopement risk. Facility notes indicated on , came to the facility and was unable to locate her. She was located in the drug store parking lot approximately 2 miles away from the facility. The resident appeared , and was taken to the facility.

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On , two days later, she walked off the facility property and down to the river without supervision. She did not want to return right away. She returned a short time later and exited the door by the pool and went onto the walking trail. She was monitored as much as possible throughout the day. Her daughter said she was looking to purchase a guard.

On at 6:45 p.m., she exited the building and made it to Eau Gallie Blvd a six lane road approximately 1000 from the facility. Staff were able to redirect her to the facility.

On at 7:30 a.m., a note signed by the Resident Care Director (RCD) indicated that she received a call by the nurse at approximately 1:25 a.m. informing her that the resident was not in her apartment. Staff were instructed to do a complete check of the entire building including the memory care unit. The RCD arrived to the facility along with the administrator at 2 a.m. A complete sweep of the building was conducted. The administrator contacted the police and daughter. The police arrived and were provided a picture of the resident and a pillow case for the K-9 unit. Security cameras captured the resident leaving the front lobby at approximately 12:30 p.m. on . She was located by the police on at 7:15 a.m. on N Harbor City Blvd a four land road also, approximately 1000 from the facility. North harbor City Blvd intersects with Eau Gallie. The resident was returned to the facility by the administrator.

On at 10:30 a.m., resident #1's physician was notified and she was placed on hourly checks. At 1:30 p.m., the facility staff remained at her side until family could provide a 24-hour sitter.

On , she was moved to memory care and a private duty aide was in place 24/7 until .

On at 3:30 p.m., she was exit-seeking and upset about not being able to leave the memory care unit.

On at 4:15 p.m., she became agitated and kept saying she wanted to get out of here.

On at 3:15 p.m., she was sitting on the bench in memory care unit watching the door all day. When the nurse exited the door, she came behind her and tried to follow her through the door.

On at 8:30 p.m., she had increased , and was looking for her luggage so she could leave. She stood near the exit door with her purse.

On at 3 p.m., she was pounding on the door trying to exit the facility. She tried to get out of the gate, forcing the gate door and forth. She shook the door so hard that the alarm went off. Staff

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monitored her closely.

On at 7:30 p.m., she was seen by staff walking in the parking lot. Staff stayed with her outside until the administrator arrived and was able to redirect her inside the building. The resident was placed on one to one supervision for the remainder of the shift and overnight.

On at 4 p.m., the administrator said that on the resident climbed over the wall but staff were with her the entire time. The wall secures the outside of the memory care unit.

On at 5 p.m., she attempted to climb the wall.

On at 8:45 p.m., she was exit-seeking, and pulling and kicking at the door.

On at 11:45 p.m., she continued to pace and pull on the door. She went from room to room lifting the window blinds and feeling around the windows for a way to open the window.

On at 2:45 p.m., she was exit-seeking and stating she had to get to Long Island.

The facility's elopement policy indicated that caregivers were to be aware of every resident they were responsible for during their shift, and mandatory shift checks would be performed between 8 p.m. and 9 p.m. This did not occur on .

The resident exhibited unsafe behavior when she left the facility on , , and . However, the facility failed to provide adequate supervision when she eloped on . The facility failed to conduct a check of the resident on the evening of , and failed to perform a search of the resident when she was not seen at 11 p.m., which could have led to an earlier search of her whereabouts. The facility's lack of action placed the resident at risk for harm.

On at 3:49 p.m., the administrator confirmed the findings.

2. Resident #2's record revealed an admission date of . A most recent 1823 health assessment form, dated , indicated her diagnoses included memory loss and . She required supervision to assistance with her Activities of Daily Living (ADLs.)

Facility notes and incident reports indicated that on at 5:30 a.m., she was yelling for help. She was found on the floor, sitting on her with her facing the bathroom. She said when she got up to go to the bathroom, she tripped over a pile of clothes that someone threw on the floor.

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On , she was moved to the memory care unit.

On at 11 p.m., muffled cries for help were heard from her room. She was found on the bathroom floor, lying on her with her pointed towards the shower. No attempts were made by her to use the pull cord, and she did not have a pendant (alert system to call for help) on. She was unable to explain what happened. The nurse determined the motion sensor in her room was not working properly. She was to be checked on hourly.

On at 6:45 p.m., she had an unwitnessed . She said she was changing her clothes into her pajamas when she slipped. She was reminded to call for assistance when and to use her walker.

On 11:05 p.m., she was found on the floor next to the bed. She said she slid out of bed. She complained of on her right side. She was instructed to ask for assistance when needed. , was ordered on .

On at 6:30 p.m., she had an unwitnessed . She was yelling for help. She was found sitting on the bathroom floor. There was water on the floor. The resident was washing her .

On at 8:15 a.m., she was found on the floor. She slid out of her shoes. Slip-on slippers were removed.

On , she had a witnessed . She sustained a on her left . She said she was going to the bathroom and slipped because she lost her balance. She was reminded to call for assistance when getting out of bed and reminded to use her walker.

On at 9:20 p.m., she was found on the floor. She was trying to toilet herself. Staff were instructed to apply non-skid socks.

On at 12 a.m., she had an unwitnessed . She was trying to go to the bathroom. She was encouraged to call for help when she needed to use the bathroom.

On at 11:45 a.m., she was found sitting on the floor next to the bathroom door. She said she was trying to toilet herself before sliding to the floor.

On at 6:15 p.m., she was found on the floor. She was yelling for help. She lost her balance.

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Non-skid socks were applied.

On at 7 p.m., she had an unwitnessed and sustained right soreness. She said she went to sit up on the edge of bed to go to the bathroom, and she slid to the floor. She was told to avoid wearing satin pajamas to avoid slipping.

On at 3:26 a.m., she had an unwitnessed . She said her hurt, so she was getting out of bed to go to the bathroom.

On at 6:30 p.m., she was observed lying on the floor near the dining room, yelling for help. She complained of right , and , . She was taken to the hospital.

On , she returned to the facility and was admitted to hospice services.

On , a hospital bed and wheelchair were received.

On , she continued to forget to use her wheelchair and walker. She was on a 2-hour toileting schedule.

On , an order for work was received.

On at 12:45 p.m., she was found sitting on the floor and stated she slid out of the bed when she tried to stand up to walk to the dining room. She was not using her walker and wore non-skid socks. She complained of tenderness on her right and declined being sent to the hospital.

Resident #2 experienced 15 between and . Despite the resident's memory loss, , and her need for supervision to assistance with ADLs, the facility's primary interventions to decrease her risk for was to remind her to call for assistance, to use her walker, and to wear non-skid socks.

On at 5 p.m., the findings were discussed with the administrator and RCD who both agreed with the findings and were unable to provide additional documentation.

Photographic evidence obtained.

Class II

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0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(i)

Based on observations, record reviews and interviews, the facility failed to make a daily effort to determine that 2 of 2 residents (#1 & 2), both of whom were at risk for elopement, had Identification (ID) on their person that included their name and the facility's name, address, and telephone number, and failed to follow its elopement policy when 1 of 3 sampled residents eloped from the facility (#1).

Findings:

1. Resident #1's record revealed a facility admission date of . An 1823 health assessment form, dated , indicated that she was an elopement risk.

Observations made of resident #1 with caregiver A on at 1:57 p.m. revealed the resident did not have ID on her person, as required. Nurse D also confirmed the finding, checked the resident's purse, but did not find an ID.

Resident #1 eloped from the facility on . The facility's elopement policy indicated that caregivers were to be aware of every resident they were responsible for during their shift and mandatory shift checks would be performed between 8 p.m. and 9 p.m. However, on at 1:16 p.m., caregiver C said she was the resident's caregiver on the p.m. shift when she eloped on . She said resident checks were conducted everyday at 2 p.m. and 9 p.m. However, on that night, she conducted her 9 p.m. check on every room except the room of resident #1 because she said she got busy. Therefore the elopement policy was not followed.

2. Resident #2's record revealed a facility admission date of . An 1823, dated , indicated she was an elopement risk.

Observations made of resident #2 with nurse D on at 2 p.m. revealed the resident did not have ID on her person, as required. Nurse D confirmed the finding and checked the resident's wallet but did not find an ID.

Both resident #1's and #2's record did not contain documentation to indicate the facility made a daily effort to determine they had ID on their person, and did not contain documentation to indicate a reason they did not have ID.

Additionally, the facility's resident elopement policy indicated that the facility would make, at a minimum, a daily effort to determine that at-risk residents have ID on their person that includes their name, the

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community's name, address, and telephone number.

Photographic evidence obtained.

Class III