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
	AL11965048	A. BUILDING: _____ B. WING _____	02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AT OVIEDO	1725 PINE BARK OVIEDO, FL 32765

(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 #2020010480 and an . . . . Control Monitoring were conducted on . Madison at Oviedo had deficiencies 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 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 and interviews, the facility failed to adequately supervise 1 of 2 sampled residents who eloped from the facility (#1). Findings: Review of a facility generated Adverse Incident Report (AIR), dated , revealed documentation that indicated on resident #1 could not be located in the facility's Memory Care Unit. He was last seen by staff between approximately 7:20 p.m. and 7:30 p.m., when he went to the outside courtyard. Following a search of the facility, law enforcement was notified at	A 025		

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A 025	Continued From page 2 8:25 p.m. and located him approximately 6 miles away from the facility on at approximately 10:25 a.m., approximately fifteen (15) hours later. He was transported to an emergency room for an evaluation and returned to the facility at approximately 2:30 p.m. on . Following an investigation by law enforcement, it was determined the resident climbed an 8- fence that surrounded the outside patio as shoe prints were found on the outside of the fence, and there was damage to the top of the fence. Review of the resident's record revealed he was admitted to the facility on . An 1823 health assessment form, dated , indicated he was an elopement risk, and his diagnoses included and advanced with behavioral disturbances. He ambulated independently without the aid of an assistive device. "Sundowners , , or sundowning, is a state of that occurs later in the afternoon and into the night. This state of is most often found in patients who have or 's and is comprised of a range of behaviors including increased , , and aggression. Sometimes people with this condition tend to pace or , and they may ignore or not hear instructions." (greatseniorliving.com/). Review of facility notes revealed the following: at 9:20 p.m. - resident #1 eloped at approximately 7:30 p.m. and was last seen by a staff member walking out of a door in memory care and into the porch area. The staff member believed he was going out to sit but when the same staff member went to check on	A 025		

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A 025	Continued From page 3 him, he was not there. A search was conducted inside and outside of the facility. at 3:30 p.m.- resident #1 was located by law enforcement and was taken to a hospital for an evaluation. He was returned to the facility at 2:40 p.m. .. .. at 5 p.m. - a sitter was at his bedside. .. .. at 7 p.m. - a sitter was at his bedside. .. .. . at 5:41 p.m. - resident #1 was discharged from the facility to another Assisted Living Facility (ALF) at approximately 2:30 p.m. At 10:59 a.m. on ..... , caregiver B said she last saw resident #1 sometime after the resident's dinner when he went outside on the patio. At 12:29 p.m. on ..... , the administrator said the details on the AIR were accurate and said a staff member called her and informed her that the resident could not be found. The administrator instructed the staff to continue their search efforts and when she arrived at the facility herself, she called 911. She said the resident used to run marathons and the police were able to determine that he jumped the fence based on footprints that were found on both sides of the fence. Following the elopement, a sitter was placed with the resident, a code required lock was installed on the patio door, and staff were instructed to remain on the patio when residents were present. Resident #1 lived in the facility's secured Memory Care Unit. His diagnoses included advanced and he was identified as an elopement risk. The facility's inadequate supervision and subsequent resident elopement directly	A 025		

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A 025	Continued From page 4 threatened the physical and emotional health, safety, and security of resident #1. Class II	A 025		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require	A 055		

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A 055	Continued From page 5 central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are	A 055		

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A 055	Continued From page 6 still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to keep a centrally stored medication in a locked cabinet, locked cart, or other locked storage receptacle, room, or area at all times for 1 of 1 sampled resident who received assistance with self-administered medications and whose medication went missing (#2). Findings: Review of a facility generated Adverse Incident Report (AIR), dated [redacted], revealed that on [redacted] at 5 p.m., nurse A reported to the director of nursing (DON) that resident #2's medication card that contained sixty tablets of [redacted] with [redacted] (#3) was missing. A search for the medication was unsuccessful and a report was made with law enforcement at 6:38 p.m. The report indicated that on [redacted], resident #1 returned to the facility following a stay at a rehabilitation facility and the medication, which he was previously prescribed, was no longer prescribed upon his	A 055		

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A 055	Continued From page 7 return. Therefore, nurse A removed two leftover medication cards from the medication cart. One contained two tablets and the other sixty tablets. She placed them in a drawer located in the nurses' station with the intent of destroying the medication with the next oncoming nurse. Nurse A became distracted and left the cards unattended and unsecured in the drawer. On [redacted], seven days later, she remembered the cards were in the drawer and when she went to retrieve them, only the card that contained two tablets was there. A search was conducted without success, and law enforcement was notified. At 9:29 a.m. on [redacted], nurse C said as a result of the incident, a locked box was mounted on a supply closet wall and if the DON was not available, the medication was placed in the box via an opening on the top and the DON, who was the only one with a key, would retrieve it at a later time. At 9:43 a.m. on [redacted], the DON said when a [redacted] required destruction the staff were required to immediately give it to him. Otherwise, if he was not available, the staff were required to place it in the locked box, as was previously indicated by nurse C. At 11:06 a.m. on [redacted], nurse A said resident #2 returned from a rehabilitation stay on [redacted], so she removed all of his medications from the medication cart, including two cards of [redacted] #3, then took them to the nurses' station and placed them in an unsecured drawer with the intent of returning later in the shift to reconcile the medications because the resident did not return with an order for the [redacted] #3. She said one of the cards held two tablets and the other	A 055		

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A 055	Continued From page 8 contained sixty. She returned to work, she believed on , and remembered the medication had to be destroyed but when she went to retrieve them from the drawer, the card that contained sixty tablets was not there. She conducted a search but was unsuccessful. At 12:29 p.m. on , the DON said the details on the AIR were accurate. The administrator said so many people went in and out of the nurses' station which made it difficult for the facility to determine exactly what happened to the card. Review of resident #2's record revealed a facility admission date of . The record contained an order, dated , for , #3 15/300 milligrams (mg,) one tablet by twice a day. A facility note, dated , indicated the resident had a , was sent to the hospital, and was later transferred to a rehabilitation facility. A facility note, dated , indicated that he returned to the facility. The resident's 1823, dated , indicated that he required assistance with self-administration of medications, and it did not contain an order for the , #3. Class III	A 055		