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
	AL11968706	A. BUILDING: _____ B. WING _____	02/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT AVALON PARK	13798 CYGNUS DR ORLANDO, FL 32828

(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 #2021000592 was conducted on [redacted]. Encore at Avalon Park had deficiencies at the time of 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 [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 [redacted] 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 59A-36.012, F.A.C.	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 (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 review and interview, the facility failed to provide appropriate care and services that included supervision and maintaining a general awareness of the resident's whereabouts for 2 of 4 residents who were at risk of elopement and eloped from the secure memory care unit (#1 & #3). Findings: During the facility entrance on . . . . . , residents #1 and #3 were identified at risk of elopement. Both residents lived in the secured memory care unit (MCU). 1. Resident #1 had a health assessment report	A 025		

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A 025	Continued From page 2 1823 dated . . . . . The report listed diagnoses of , high , , ... , and early stage . . . . . She was alert and oriented with and was at risk of elopement. Health assessment dated also indicated she was at risk of elopement. Facility notes indicated the resident had a long history of exit seeking behavior. . . . . . exit-seeking, continues . . . . in the evening. Looks for exit to go home, find her German shepherd dog. Was easily redirected Exit-seeking throughout day, needed to get dog. continued exit-seeking through shift . . . . . continued exit-seeking, asked several times when she could go home - redirect with . . . . . somewhat effective and /exit-seeking . . . . . exit-seeking, knocking on doors requires constant redirecting/ . . . . . at 3:22 PM resident was exit seeking, trying to open doors . . . . . at 2:23 PM resident continued to exit seek. She pushed the emergency doors until the alarm went off. She continued to step outside; a caregiver was able to redirect her. . . . . . at 6:50 AM The receptionist called MCUat 2:30 PM to say someone called to say they had seen an elderly woman ambulating without a walker and seemed . . . . . A count was done, once it was realized that a resident was missing, a search was done. The resident was found "immediately" and brought to facility at 3 PM. Adverse reports indicated that on . . . . . at 1:50 PM the resident was exit-seeking during and after lunch, asked	A 025		

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A 025	Continued From page 3 assistance how to get out of building. Said mother was sick and needed to go. Reassurance given. . . . given as scheduled without effect. At 1:50 PM exited the building through fire doors. The fire alarm door went off and alerted caregivers. She ambulated fast. Resident was found by caregiver just outside the building fire exit. Redirected . . . to building. . . . . . exit-seeking during and after lunch. At 2:17 PM, exited through fire doors. Fire door went off, to alert caregivers "but they were out of sight at the moment" attending to other residents. 2. Record review for resident #3 revealed a health assessment report 1823 dated . . . . . that indicated he was not at risk of elopement. Health assessment report 1823 dated . . . . . listed diagnoses of 's with , , , ... , . . . , high . . . . . , ... , and deep stimulator , . According to the health assessment, he was at risk of elopement and had and , cognition. Facility note dated indicated the resident attempted to open the gate of the courtyard, unsuccessfully. Facility note dated at 6:48 AM revealed the resident was in the memory care unit hallway while the nurse administered medications at 6:30 AM. An undentifed person (not a staff) brought the resident to the facility. Adverse report dated at 6 AM, indicated the resident was out (of the facility) for 30 minutes. Neighbors found him wondering at 6:30 AM. The front door was not locking properly and he was able to open the door in the lobby area and exited by front door. There was an employee at the lobby and did not notice him.	A 025		

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A 025	Continued From page 4 Another staff noticed the door was open. The staff who worked the front desk did not question why the door was open and did not notify the nurse. On at 2 PM, the administrator said the Fire Marshall made them remove the cover that made the door look like a bookcase, and now the resident got interested in the door. The doors were not locking properly. Maglocks and fobs were installed. Both locks to entrance doors to MCU were replaced with fob locks. Locks to emergency exit doors were changed, maglocks were installed. Staff can open mag locks and would open in case of fire. An elopement in-service was also held. Class II	A 025		