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
	AL11969591	A. BUILDING: _____ B. WING _____	03/16/

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERTUS WL OPCO LLC	11120 LAKE UNDERHILL ROAD ORLANDO, FL 32825

(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 #2021003174, Infection Control and Generator Monitoring were conducted on 3/16/ . Certus WL OPOC LLC had a deficiency 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 dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. 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 appointments 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		

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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, interview and record review, the facility failed to monitor and maintain a general awareness of a resident's whereabouts, appropriate to the needs for 1 of 7 sampled resident (#2). Findings: Resident #2's record reflected an admission to the Memory Care facility on 12/14. . Resident #2's 1823 assessment form, dated 12/11/ , revealed a medical history of The resident was with activities of daily living and	A 025		

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A 025	Continued From page 2 with The 1823 assessment form also reflected the resident was upon admission to the facility. Resident #2's record revealed that the facility did not put in place interventions or increased supervision at the time of admission to ensure the safety of the resident and to prevent an from occurring. The facility's Adverse Incident Report, dated 2/22/ , revealed that on 1/05/ resident #2 eloped from the facility by opening a window in his room, breaking the screen, and crawling through the window to the open area outside his window that leads to the main road. The staff noticed him missing after breakfast. After the facility was searched inside, resident head count was completed, the perimeter grounds were searched, and staff alerted law enforcement. The resident walked along a busy 4 lane street that runs along the facility grounds. He was found approximately an hour later by law enforcement a half a mile from the facility at an abandoned gas station. Photographic evidence attached. In an observation and tour of the facility on 3/16/ at , it revealed the facility is a Unit with resident rooms that face either a courtyard with no exit to the main street and rooms that face an open area of the facility that has access to the main driveway and main road. Resident #2 was placed in a room with a window that faces the open area. On 3/16/ at the Director of Wellness confirmed no interventions or increased supervision was put into place for resident #2 at the time of the admission. She stated all residents are observed every 2 hours including resident #2.	A 025		

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A 025	Continued From page 3 On 3/16/ at , staff E stated she was not aware that resident #2 was an he did not receive any additional supervision from staff, and was not aware of any interventions in place for the resident #2. On 3/16/ at staff G stated there was no intervention in place for resident #2. She said she was not aware that he was an and there was no increased supervision for the resident. At staff G stated she was not aware resident #2 was and there were no interventions or additional instructions of increased supervision for the resident. On 3/16/ at , the administrator confirmed the findings to include not having interventions put in place and increased supervision for resident #2 upon admission. Class II	A 025		