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
	AL11969022	A. BUILDING: _____ B. WING _____	01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING FACILITY	2250 S SEMORAN BLVD ORLANDO, FL 32822

(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 #2022000572 was conducted on [redacted] Assisted Living Facility had deficiencies at the time of visit.	A 000		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed	A 008		

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A 008	Continued From page 1 through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special	A 008		

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A 008	Continued From page 2 needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of or any other communicable, which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in	A 008		

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A 008	Continued From page 3 an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment,	A 008		

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A 008	Continued From page 4 Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish , to be administered in the case of or . (f) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain a completed and accurate health assessment report for 1 of 3 sampled residents (#1). Findings: Resident #1's health assessment report, dated , did not indicate if the resident was at risk of elopement. Page 2 -section C reflected	A 008		

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A 008	Continued From page 5 that she needed 24-hour nursing or , , , care. On at 1:22 PM, the administrator confirmed the finding. Class III	A 008		
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,	A 025		

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A 025	Continued From page 6 including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 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 records review and interview, the facility failed to provide appropriate supervision to 2 of 2 sampled residents afflicted with [redacted], who eloped from the facility; and failed to maintain written notations regarding the elopement of resident #1 and notification to responsible party (#1 & 3). Findings: The facility's elopement policy and procedures defined an elopement as a "situation when a	A 025		

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A 025	Continued From page 7 resident leaves the facility grounds without staff knowledge and fails to follow policy for signing in and out." 1. Resident #3's updated health assessment, dated , listed diagnoses of , , high , and was alert and oriented to person and place. The health assessment, dated , listed diagnoses of early , poor memory, need of supervision, and driving was not allowed. The health assessment, dated , listed diagnoses of , , and , was an elopement risk and required residence in the memory care unit (MCU). According to this health assessment, she was alert and oriented to person only, had short-term memory, was a risk, was independent in ambulation, eating, toileting and transferring; and required supervision with , grooming and assistance with bathing. A facility note dated at 10:39 PM read, "Observed trying to eat trash. Gets a little aggressive at dinner. Also, going into other people's apartments." A facility note dated at 8 AM indicated memory continued to be , , was able to recall three items, but not after two minutes; does not know year, month, or city. A facility note dated indicated a late entry for at 6 PM which reflected that a caregiver called to report that the Orlando Police Department called the community to notify the resident had been found , around the apartment , adjacent to the community. The resident was last seen at 4:05 PM following resident #2 around the community.	A 025		

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A 025	Continued From page 8 The resident was safely returned by the Orlando Police Department. The resident's family and health care provider were notified. The resident was immediately placed on one to one supervision pending the resident's adult child obtaining a private caregiver. An Adverse Report, dated , reflected that resident #3 followed resident #2 out of the building and wanted to get in her car. The other resident was alert and oriented and was re-directed to the facility. Resident #3 left the community on her own. She was found in an apartment , nearby and "appeared lost". The local police contacted the facility, and she was returned. The facility was not aware of the resident's whereabouts from 4 PM, when she was last seen by staff, until a call was received from the Orlando Police Department at 6 PM, two hours later when she was found in an apartment , (location unknown). She was discharged to another facility on . 2. Resident #1's health assessment report dated listed diagnoses , on , type 2, high , , physical deconditioning, and a history of . According to the assessment, she was not at risk of elopement. She was alert to name only, was independent in eating and grooming, and required supervision with all other activities of daily living. The healthcare provider's order, dated , indicated the reisdent needed Long-Term Care or memory care unit placement for . A facility note dated at 4:14 PM reflected that the resident had made multiple	A 025		

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A 025	Continued From page 9	A 025		

attempts to elope from the community. Staff successfully redirected the resident and would "continue to monitor".

A facility note dated 10:55 AM reflected that the advanced practice registered nurse saw the resident in , 2021. The note indicated the resident "Eloped recently, will be transferred to memory care."

On at 1:22 PM, the administrator stated he could not recall clearly that resident #1 eloped on . He then stated the resident went to the supermarket next door, and forgot to sign out. A hospice staff came to visit the resident, looked for the resident and was unable to locate her. She was not in the facility. The facility started elopement procedure. The hospice staff reported her missing to Department of Children and Families (DCF). The resident returned to the facility with her groceries. She was informed she needed to follow the facility's policies and procedure. The resident returned before law enforcement was called. He recalled having notations regarding the elopement in the office.

Maps.com indicated the said supermarket was 0.3 miles away from the facility. The resident was discharged from the facility on .

The facility was not aware resident #1 left the facility until a hospice staff was unable to locate the resident within the facility grounds on .

Class II