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
	AL11910126	A. BUILDING: _____ B. WING _____	10/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

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A 000	Initial Comments Complaint Investigations #2022010547, #2022011550, #2022014751, and a Generator Monitoring were conducted from . Grand Villa of Altamonte Springs had deficiencies at the time of the survey.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice,	A 010		

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A 010	Continued From page 1 and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010		

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A 010	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and,	A 010		

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A 010	Continued From page 3 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are	A 010		

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A 010	Continued From page 4 described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to obtain a new 1823 Health Assessment Form for 1 of 13 sampled residents after a significant change for continued residency by the healthcare provider as required (#8), and failed to obtain a new 1823 Health Assessment Form for 1 of 13 sampled residents completed by the healthcare provider after two elopement occurrences (#12). Findings: 1. Resident #8's record revealed an admission date of . The last 1823 Health Assessment dated listed medical history of 's , Degenerative Disk , memory loss, low , and . She needed assistance with all activities of daily living (ADLs) for ambulation, bathing, grooming, eating, toileting and transferring, was a risk, and needed assistance with self-administration of medications. A hospice interdisciplinary certification dated , reflected that resident #8 was admitted to hospice care, which is a significant change. There was no documented evidence that a new 1823 Health Assessment was completed by the healthcare provider for this significant change. 2. Resident #12's record revealed an admission date of . The last 1823 Health Assessment dated listed medical history of and mild memory	A 010		

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A 010	Continued From page 5 loss. She ambulated with a walker and needed assistance with all activities of daily living (ADLs) for ambulation, bathing, grooming, eating, toileting and transferring. She needed assistance with self-administration of medications. The resident was not identified as an elopement risk. The first elopement occurred on at 8:50 AM. Resident #12 walked over to a supermarket next door, could not remember how to get . . . to the facility and asked the store employee to send her to the facility or escort her . . . . Resident #12 could not recall the name of the facility to the store employee. However, the store employee was familiar with the assisted living facility nearby, looked up the telephone number to the facility and called. The assisted living activities director walked over to the supermarket and walked resident #12 . . . to the facility. The Director of Nursing (DON) completed a skin check. There were no visible injuries. The family member and healthcare provider were contacted. On . . . . . at 10:30 AM, an interview with the assisted living activities director confirmed that she walked resident #12 . . . from the supermarket after the facility received telephone a call from the store that resident #12 was lost and did not know how to get on her own. The second elopement occurred on at 3:40 PM. Resident #12 was returned to the front desk to the facility by a Good Samaritan saw resident #12 walking near the supermarket next door and stated that resident #12 could not recall the event and appeared . . . . . The front desk receptionist checked the resident's sign in/sign out log and did not see that resident #12 signed out per the facility's policy. The DON completed a	A 010		

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A 010	Continued From page 6 skin check. There were no visible injuries. The family member and healthcare provider were contacted. A facility note dated . . at 5:30 PM, two hours after the resident returned from the second elopement, the facility placed resident #12 into the Memory Care unit. The family member and healthcare provider were notified of the move. On . . . . . at 3:45 PM, the Front Desk receptionist who received resident #12 into the facility after the Good Samaritan brought her , stated she did not really remember the event. She further stated she signs lots of visitors and residents in and out all day. On at 2:20 PM, the Administrator confirmed the findings. Class III	A 010		
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	A 025		

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A 025	Continued From page 7 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, 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.	A 025		

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A 025	Continued From page 8 This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide adequate supervision to 2 of 11 sampled residents who eloped from the facility (#10 & #12), and to 2 of 11 sampled residents who were involved in a physical altercation (#5 & #14). Findings: Review of the facility's undated Resident Elopement Policy revealed the facility defined elopement as "A situation in which a resident cannot be located in the community and their whereabouts are unknown and/or the resident leaves the community without following the community's policy and procedure." 1. Resident #10's record revealed a facility admission date of . An 1823 health assessment form, dated , indicated the resident's diagnoses were , , and . The form also indicated the resident was at risk for elopement. A facility pre-determination assessment, dated , indicated the resident exhibited exit-seeking and pacing behaviors. An 1823, dated , indicated the resident was at risk for elopement. A facility incident report indicated that resident #10 eloped from the facility on and was last seen on that day participating in activities at 2:45 P.M. The report indicated that review of cameras revealed the resident exited through the Memory Care doors into a hallway at approximately 3:30 P.M. The resident pulled the fire alarm in that hallway at approximately 3:50	A 025		

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A 025	Continued From page 9 PM, then exited through a door and gate at approximately 3:51 P.M. The resident was located by the Memory Care Director at approximately 4:02 PM at the of the building leaning against a wall next to a dumpster. The resident was brought inside. The resident did not sustain any injury. The facility's analysis of the elopement indicated the resident was seen on camera following a staff member through the hallway door. The corrective action was that staff were in-serviced on making sure the door shut behind them and that no residents followed them out. A facility note, dated at 5:15 PM, indicated resident #10 went behind an associate into the stairwell entrance. The resident then pulled fire alarm to leave through the entrance of the locked Memory Care neighborhood. The resident was found standing by the dumpster and was as to why staff were asking her to come inside. A facility investigation note, dated at 10:30 AM, indicated resident #10 was able to follow an employee into the stairwell on . While in the stairwell for approximately 15 minutes, the resident pulled the fire alarm. The resident was located "approximately 5 minutes behind the community near the smoking section", then was escorted inside. Staff were educated to always be aware of their surroundings upon exiting and entering the memory care building. Staff was encouraged to stay close to the door until the red light returned on the door, confirming that the door was locked. On at 4:25 PM, resident #10 sat in a dining room chair in the Memory Care unit. When asked about the time, she left the facility and was	A 025		

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A 025	Continued From page 10 brought . . . inside by staff, she replied "I'd never leave. I'd be afraid the . . . police would get me." During an interview with the Memory Care Director on . . . . . at 12:15 PM, she said that on at approximately 3:30 PM, the fire alarm sounded. She responded to the Memory Care building where she learned that resident #10 could not be found. The Memory Care Director then searched outside and found the resident leaning against a wall near a dumpster located on the property. The Director brought the resident, who she said was sweaty, . . . inside the facility. The Director said the resident normally stood near the exit door and told anyone who entered and exited that she wanted to go outside to have a cigarette. The director said to prevent the resident from eloping again, the staff tried to take the resident out to smoke as often as they could, and they also encouraged the resident to sit on the patio. The Director said the resident eloped by following Caregiver C through the first secured door, which led to a hallway where a fire pull station was locked. It was there the resident pulled the alarm which released the lock on the next door and the outside gate, allowing the resident to get outside. On . . . . . at 3:20 PM, Caregiver C said that on she entered a stairwell and did not look . . . to see if a resident was behind her. The Caregiver said she received education following the resident's elopement on ensuring she checked for residents coming through doors behind her. 2. Resident #5's record revealed a facility admission date of . An 1823, dated . . . . , indicated the resident's diagnoses were , . . type 2,	A 025		

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A 025	Continued From page 11 , and A facility note, dated at 3:30 PM, indicated that resident #14 choked resident #5. Resident #5's and were red. The resident denied , had no difficulty breathing, and was able to take food and water by without difficulty. A facility note, dated at 7:15 PM, indicated that resident #5's guardian questioned the facility's administrator on how the choking incident could happen and that she believed staff should be on the floor at all times. The administrator responded by explaining that the caregiver was providing care to another resident and that an Activities Assistant was present. Resident #14's record revealed a facility admission date of . An 1823, dated , indicated the resident's diagnoses were . Diastolic , , and . A facility note, dated at 3:30 PM, indicated this resident was seen by staff grabbing resident #5 by her and choking her. Staff intervened and took this resident to his room. Staff called the police, who indicated that this resident did not meet criteria due to his diagnoses. The facility placed one-on-one supervision with him. He later barricaded himself in his room and said he was going to the place down. Police were called again and during their second visit, the resident swung a cup at an officer, at which time the resident was handcuffed and taken to the hospital. He did not return to the facility.	A 025		

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A 025	Continued From page 12 On [redacted] at 4:10 PM, resident #5 sat in a dining room chair in the Memory Care unit. Her responses to questions were not appropriate and she changed topics often. She did not have any visible injuries. On [redacted] at 3:50 PM, Caregiver E said she was in another resident's room when she heard screaming when resident #14 choked resident #5. She responded to the common area and saw resident #14 choking resident #5. She grabbed resident #14's [redacted] and removed them from resident #5's [redacted]. She said resident #5 remained angry but she was able to take him to his room. She said there was no staff present in the common area at the time of the incident. On [redacted] at 4:25 PM, the Activity's Assistant said when resident #14 choked resident #5, she was not present and learned of the incident when she heard someone call for help over the radio. 3. Reports dated [redacted] and [redacted] were submitted to the Agency for Health Care Administration for two separate elopement occurrences for resident #12. Photographic evidence was obtained. The first elopement occurred on [redacted] at 8:50 AM. Resident #12 walked over to the supermarket next door, could not remember how to get [redacted] to the facility, and asked the store employee to send her [redacted] to the facility or escort her [redacted]. Resident #12 could not recall the name of the facility to the store employee. However, the store employee was familiar with the assisted living facility nearby and called the facility. The Activities Director walked over to the supermarket and escorted resident #12 [redacted] to the facility. The Director of Nursing (DON) completed a skin	A 025		

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A 025	Continued From page 13 check. There were no visible injuries. The family member and healthcare provider were contacted. On at 10:30 AM, the Activities Director confirmed that she walked resident #12 from the supermarket after the facility received a telephone call from the store that resident #12 was lost and did not know how to get on her own. There was no documented evidence that an any additional supervision for resident #12 was put in place. The second elopement occurred on at 3:40 PM. Resident #12 was returned to the front desk to the facility by a Good Samaritan who saw resident #12 walking near the supermarket next door and stated that resident #12 could not recall the event and appeared . The front desk receptionist checked the resident sign in/sign out log and saw that resident #12 did not sign out per the facility's policy. The Director of Nursing (DON) completed a skin check. There were no visible injuries. The DON contacted the family member and healthcare provider about the elopement. A facility note, dated at 5:30 PM, two hours after the resident returned to the facility, the resident was placed on the Memory Care unit. The family member and healthcare provider were notified of the move. On at 3:45 PM, the front desk Receptionist stated that she did not really remember the event. She stated she signed lots of visitors and residents in and out all day. Resident #12's record revealed an admission date of . The last 1823 Health	A 025		

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	AL11910126	A. BUILDING: _____ B. WING _____	10/11/2022

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A 025	Continued From page 14 Assessment, dated [redacted], listed a medical history of [redacted] and mild memory loss. She ambulated with a walker and needed assistance with all activities of daily living (ADLs) for ambulation, bathing, grooming, eating, toileting and transferring. She needed assistance with self-administration of medications. Photographic evidence was obtained. On [redacted] at 4:20 PM, an interview with the Administrator confirmed the findings. Class II	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. 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 this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons	A 032		

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A 032	Continued From page 15	A 032		

that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times.
2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative.
(b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for:
1. An immediate search of the facility and premises,
2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,
3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and,
4. The continued care of all residents within the facility in the event of an elopement.
(c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S.

This Statute or Rule is not met as evidenced by:

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A 032	Continued From page 16 Based on observations, record reviews, and interviews, the facility failed to ensure its elopement policy contained the required information and failed to make a daily effort to ensure 2 of 2 sampled residents, who eloped from the facility, had identification (ID) on their person that included their name and the facility's name, address, and telephone number (#10 & #12). Findings: 1. Resident #10's record revealed documentation that indicated the resident eloped from the facility on . . . . Review of 1823 Health Assessments dated and both indicated the resident was at risk for elopement. The record did not contain documentation to indicate the facility made a daily effort to ensure the resident had ID on her person that included her name and the facility's name, address, and telephone number. Review of the facility's undated resident elopement policy revealed it did not contain the required language to indicate that it would make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Observations made with the Memory Care Director of both resident #10 and #12 on at 1:08 PM revealed neither resident had ID on their person. During an interview with the administrator on . . . . . at 4:20 PM, he confirmed the elopement policy did not contain the required provision that a daily effort would be made to ensure resident's at-risk for elopement had ID on their person.	A 032		

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A 032	Continued From page 17 2. On at 8:50 AM, resident #12 walked over to the supermarket next door, could not remember how to get to the facility, and asked the store employee to send her to the facility or escort her . Resident #12 could not recall the name of the facility to the store employee. However, the store employee was familiar with the assisted living facility nearby and called the facility. The Activities Director walked over to supermarket and escorted resident #12 to the facility. The Director of Nursing (DON) completed a skin check. There were no visible injuries. The DON contacted the family member and healthcare provider about the elopement. On at 10:30 AM, the Activities Director confirmed that she walked resident #12 from the supermarket after the facility received telephone call from the store employee that resident #12 was lost and did not know how to get on her own. The second elopement occurred on at 3:40 PM. Resident #12 was returned to the facility by a Good Samaritan who saw resident #12 walking near the supermarket next door and stated that resident #12 could not recall the event and appeared . The front desk Receptionist checked the resident sign in/sign out log and saw that resident #12 did not sign out per the facility's policy. The DON completed a skin check. There were no visible injuries. The DON contacted the family member and healthcare provider about the elopement. A facility note, dated at 5:30 PM, two hours after resident #12 returned to the facility, the resident was placed on the Memory Care unit. The family member and healthcare provider were	A 032		

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A 032	Continued From page 18 notified of the move. There was neither documented evidence that an elopement assessment was completed, nor any additional supervision put in place to ensure resident #12's safety. There was no documentation that the facility made a daily effort to determine if resident #12 had identification on her persons to include the resident's name, facility's name, facility's address, and facility's telephone number. On [redacted] at 4:20 PM, the Administrator confirmed the findings. Class III	A 032		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [redacted] to ensure easy access by the resident,	A 152		

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A 152	Continued From page 19 2. A closet or wardrobe space for hanging clothes, 3. A dresser, . . . or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain a free of hazards by repairing a water leak in 1 of 13 sampled resident rooms (#6). Findings: On at 10:15 AM, resident #6 was in his bed resting. The resident was asked about the missing ceiling tiles and a 100-gallon trash can in his room, and if there was a leak. He said they were renovating his room. He did not want to talk further. On . . . . . at 3 PM, the Administrator confirmed that there was a leak in the resident's room from the window, possibly from Hurricane Ian. The administrator was not able to provide any documentation about the repairs being done in resident #6's room.	A 152		

Agency for Health Care Administration

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A 152	Continued From page 20 Class III	A 152		