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
	AL11969199	A. BUILDING: _____ B. WING _____	11/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDERMERE ASSISTED LIVING FACILITY CORP	7050 BRAMLEA LN WINDERMERE, FL 34786

(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 #2022010155 and a Generator Monitoring were conducted on . Windermere Assisted Living Facility Corp. had deficiencies at the time of the survey.	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 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	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 provide care and services to meet the needs of residents by failing to provide adequate supervision to 1 of 6 sampled residents who eloped from the facility (#5). Findings: Resident #5's record revealed a facility admission date of [redacted]. An 1823 health assessment form, dated [redacted], indicated the resident's diagnoses was [redacted], that the resident was alert to self, had memory loss and moderate [redacted], and was an elopement risk.	A 025		

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A 025	Continued From page 2 Facility notes dated . . . and . . , both indicated the resident . . throughout the night. A facility note, dated . . . . . ., read, "In the afternoon 1:44 pm from video clip resident walk house after searching police notified at 2:35 pm family 2:56 pm doctor 3:04 pm". A facility report, dated , indicated the resident walked out of the facility on . . . . . at 1:44 PM. A facility camera's footage showed facility co-owner A entered the facility via the . . . door at 1:28 PM to relieve caregiver B, who was seen on camera exiting the facility via the front door at 1:39 PM. Co-owner A realized at 2 PM that the resident was missing. The facility's analysis of the incident was that co-owner A failed to secure the screen door when she entered the door. The corrective action was that the facility changed the security system and installed a self-closing door, employees were trained, and a plan was made with family to make the resident wear an electronic device. A law enforcement supplemental report, dated . . . . . at 9:51 AM, indicated resident #5 was located in a retention pond and "was disoriented and appeared to be exhausted". The resident was taken to the hospital, but to date the Agency has not received the requested records. The only documentation found related to the resident condition was when he was found which was in the law enforcement supplement report listed above. Based on staff interviews the resident was last seen on at 1:30 PM in the kitchen of the facility. The resident was found on at 9:51 AM. The resident was missing for approximately 21 hours.	A 025		

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A 025	Continued From page 3 The facility's undated Elopement Policy defined elopement as "When staff determines a resident is missing or whenever a resident leaves the secured confines of a memory care facility unattended by staff or family". On . . . . . at 11:34 AM, caregiver B said that on . . . . . at approximately 1:30 PM, she saw resident #5 standing in the kitchen. She went on a break when co-owner A arrived at the facility and while driving in her car, the co-owner called her to return to the facility to help search for the resident. Upon her return, caregiver B aided in the search, but the resident could not be located. Caregiver B said that prior to the resident's elopement, he frequently approached doors and windows. She also said she received elopement training following the incident. On . . . . . at 11:39 AM, co-owner A said that on . . . . . she arrived at the facility at 12 PM and at approximately 1:30 PM, caregiver B went on break. At approximately 1:45 PM, the co-owner returned to the common area after having provided care to another resident and was unable to find resident #5. She called caregiver B to return to the facility, at which time they both searched the facility but were unsuccessful in locating the resident. The co-owner said that at the time of the elopement, the . . . . . door "was broken" and did not latch properly. She said prior to the resident's elopement, he had previously tried opening doors. She said she received elopement training following the incident. On . . . . . at 11:53 AM, the administrator said the lock that was on the . . . . door at the time of the resident's elopement required a code to both unlock and lock the door. He believed that when co-owner A entered the facility to relieve caregiver	A 025		

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A 025	Continued From page 4 B for her break, she did not lock the . . . porch screen door and the door that led into the facility. He said the same door that led into the facility had a "little " in which the door did not fully close if not pushed. He said following the elopement, he installed a new lock that locked automatically and that did not require a code to do so. He said the camera footage from the incident was saved for only thirty days. On . . . . . at 12 PM, a child proof device was seen on the inside handle of the door. The administrator said the device was on the door when resident #5 eloped and that the resident was not able to squeeze the device to turn the handle but because the co-owner did not push the door to ensure it closed, the device was not a deterrent. On at 12:15 PM, co-owner A said that when she entered the facility on . . . . . she did not lock the screen door and did not push the . . . door to ensure it closed. On . . . . . at 1:20 PM, the administrator showed the surveyor the retention pond where the resident was located by law enforcement, which was approximately one mile from the facility. 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	A 032		

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A 032	Continued From page 5 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 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:	A 032		

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A 032	Continued From page 6 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: Based on observations, record reviews, and interviews, the facility failed to make a daily effort to ensure 1 of 6 sampled residents, who was at risk for elopement, had identification (ID) on their person that included their name and the facility's name, address, and telephone number (#1). Findings: Resident #1's record revealed a facility admission date of . An 1823, dated , indicated the resident was an elopement risk. The facility's undated resident elopement policy indicated "the at-risk resident will be provided with ID that includes the resident's name, the facility name, address and phone number. Staff will make a daily effort to ensure that resident have ID on their person". Observations made of resident #1 on at	A 032		

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A 032	Continued From page 7 10:05 AM revealed the resident did not have ID on her person. The resident's record did not contain documentation to indicate the facility made a daily effort to ensure that she had ID on her person. On [redacted] at 12:45 PM, the administrator confirmed the findings and was unable to provide additional documentation. Class III	A 032		