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 _____	08/14/2023

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

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CZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's ␣␣␣, to the Federal Bureau of Investigation for a national criminal history record check unless the person's ␣␣␣ are enrolled in the Federal Bureau of Investigation's national retained print ␣␣␣ notification program. If the ␣␣␣ of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit ␣␣␣ electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ␣␣␣ to the Federal Bureau of Investigation for a national criminal history record check. The ␣␣␣ shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print ␣␣␣ notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person ␣␣␣. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or	CZ816		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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CZ816	Continued From page 1	CZ816		

professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:
(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;
(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and
(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.

435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers:
(2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer.

59A-35.090 Background Screening.
(2) Processing Screening Requests, Required Documents and Fees.
(d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Service

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CZ816	Continued From page 2 s/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview the facility failed to obtain a signed background screening compliance attestation for 1 of 3 sampled staff (A).	CZ816		

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CZ816	Continued From page 3 Findings: Review of Caregiver staff A's record review revealed hire date . There was no evidence documented of a signed background screening compliance attestation. On at 4:52 PM - The Business Office Director confirmed the findings. Unclassified	CZ816		
A 000	Initial Comments A complaint investigation #2023003466 was conducted at Certus WL Opco LLC on . The facility 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	A 010		

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A 010	Continued From page 4 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, 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	A 010		

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A 010	Continued From page 5 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. (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 010		

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A 010	Continued From page 6 (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 [illegible] 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, 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 [illegible] 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.	A 010		

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A 010	Continued From page 7 (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 described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on resident record review, observation and interview, the facility failed to obtain a new AHCA Form, 1823 Health Assessment completed by the healthcare provider for continued residency after a significant change for 2 of 3 sampled residents (#1, #2) as required in an assisted living facility (ALF). Findings: 1. Review of resident #1's record revealed a facility admission date of A 1823 Health Assessment indicates the resident's diagnosis was , ˘ communication . . . . . , resides in the facility's secured memory unit and was not identified as an elopement risk. On . . . . . at The Wellness Director stated, we've also installed the ring doorbell cameras since Resident #1's elopement. The Orange County Sheriff's Report states, During the investigation, it was determined that	A 010		

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A 010	Continued From page 8	A 010		

the person in question was an unreported missing person (classified as endangered) around the neighborhood. Resident #1 had slurred speech and could not verify her name or address, or any other pertinent information. Therefore, additional deputies responded to the nearby group home for elderly people, and it was determined that Resident #1 had been missing from there.

The Florida Department of Children and Families Intake # 2023-057653-01 states on , Resident #1 was observed through a neighborhood. She apparently left the facility she is currently residing at. The facility has a security problem to where things are left unsecured, which is how Resident #1 was able to get out. A bystander noticed. Resident #1 and called 911 at 9:18PM. Resident #1 was later returned to the group home around 9:53 PM. A nurse had last seen Resident #1 at 8:30PM while making her rounds. From between 8:30PM and 9PM is when she could of went missing. No one from the facility knew she was missing, and no one called 911. Resident #1 did appear to be even though she was a half a mile to a mile away from the facility.

On at 3:32pm The Administrator stated she was unaware resident #1 new 1823 did not indicate elopement risk or that it needed to continue as such being that she was placed on Hospice.

2. Review of resident #2 record revealed a facility admission date of . A 1823 Health Assessment indicates the resident's diagnosis was adjustment with , periods of , resides in the facility's secured memory unit, and was not identified as

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A 010	Continued From page 9 an elopement risk. A facility's note on . . . . . at 13:03 states resident attempting to exit seek at this time to the front door. Resident exhibiting increased verbal aggression at this time. On at 1:20pm The Maintenance Director stated, this is memory care and mostly all the residents exit seeks. I only witnessed resident #2 attempting to exit 1 time during Sundowning. On at 3:15pm Staff D stated yes, Resident #2 would try to get out. He gets upset and wants to go to his house outside of the community. Lately, he hasn't tried to get out. He tried to get out the front door in the town hall community. On . . . . . at 3:32pm The Administrator stated she was aware that resident #2 1823 Health Assessment needed to reflect as elopement risk. 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	A 025		

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A 025	Continued From page 10	A 025		

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 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

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A 025	Continued From page 11 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 observations, record reviews and interviews, the facility failed to provide adequate supervision to 1 of 3 sampled residents who eloped from the facility's secured memory care unit (#1). Findings: Review of resident #1's record revealed a facility admission date of . A 1823 Health Assessment indicates the resident's diagnosis was , communication , resides in the facility's secured memory unit and was not identified as an elopement risk. Review of resident #1's original 1823 Health Assessment dated identified the resident as an Elopement Risk. On at 9:23am The Regional Director of Engagement stated he was unaware of any residents eloping or attempting to elope. He stated the residents may occasionally go to the door but does not push it to go out. On at 9:43am Resident #1 was observed with no Identification on her person at the exit door North end hallway of Meadowbrook. The resident was standing at the door rubbing the exit bar unsupervised for approximately minutes. The resident returned down the hall to	A 025		

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A 025	Continued From page 12 the common area. Resident #1 was asked if she was attempting to exit, and the resident stated I don't know. Resident #1 was then asked if she does this often and replied I don't understand what you're saying. On . . . . . at 9:48am Staff B stated she was unaware of any residents eloping, but Resident #1 is always at the door. Staff B stated she was never notified when resident #1 is at the exit door. Staff B stated everyone just keeps an . , . . on resident #1, but she was never informed that resident #1 needed to be watched. On . . . . . at 10:22am The Wellness Director stated we are memory care and residents will attempt exit seeking. I'm not aware of any residents who has eloped, but resident #1 is more . . . . . than others. Resident #1 checks the doors more often than others. Not sure if she's trying to get out or just trying to get somewhere. The Wellness Director stated Resident #1 correlates the outside with getting to her cats. The Wellness Director stated, we attempt to redirect and sometimes she's not , . We sometimes use pharmaceutical measures. If Resident #1 is at the exit door the concierge will radio to make us aware. We've also installed the ring doorbell cameras since Resident #1's elopement. On . . . . . at 12:59pm The Administrator provided a screen shot on her cell phone of the case #23-11008 from the Orange County Sheriff. The Administrator stated the Regional Director of Engagement was able to provide and confirmed he was present as the time of the incident. The Orange County Sheriff's Report states,	A 025		

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A 025	Continued From page 13 During the investigation, it was determined that the person in question was an unreported missing person (classified as endangered) ⌄ around the neighborhood. Resident #1 had slurred speech and could not verify her name or address, or any other pertinent information. Therefore, additional deputies responded to the nearby group home for elderly people, and it was determined that Resident #1 had been missing from there. The Florida Department of Children and Families report states on ... ., Resident #1 was observed ⌄ through a neighborhood. She apparently left the facility she is currently residing at. The facility has a security problem to where things are left unsecured, which is how Resident #1 was able to get out. A bystander noticed Resident #1 and called 911 at 9:18PM. Resident #1 was later returned to the group home around 9:53 PM. A nurse had last seen Resident #1 at 8:30PM while making her rounds. From between 8:30PM and 9PM is when she could of went missing. No one from the facility knew she was missing, and no one called 911. Resident #1 did appear to be even though she was a half a mile to a mile away from the facility. On at 1:20pm The Maintenance Director stated prior to the elopement, the doors were not being checked and we did not know they needed to be check. The weekly schedule started ⌄ due to resident#1 getting out. The service company is Stratos or Silver sphere and they only come whenever there is a problem. There is nothing set for annual maintenance. On at 1:40pm, Accompanied by the Maintenance Director the route taken by Resident	A 025		

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	AL11969591	A. BUILDING: _____ B. WING _____	08/14/2023

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A	Continued From page 14 #1 was observed (video evidence obtained). The main entry door to the Meadowbrook neighborhood is opened during normal hours and locks between 4:00pm -4:30pm before dinner. The door located at Bistro East was secure and required a key fob to unlock as well as the exit door located at the . . . of the building identified as laundry, loading dock, or breakroom. The maintenance director stated he received an alert on his phone that a door was open by the staff and heard on the ring doorbell that a resident had eloped. He stated upon his arrival to the facility, he noticed the key fob , light showed red, but he was able to push the door open without using his key fob to gain entry into the building. The maintenance director stated Staff D informed him that lightning had struck the building between 7:30p-8p. He stated he called the after-hours number about 10pm or later. According to Stratos diagnostic, it was a fuse that blew due to the lightning strike. The company was able to talk the maintenance director through how to do the diagnostic. It took about 2 hours and the staff remained at all doors until he got them to lock. The maintenance director stated that the ring cameras were installed at the exit door and front door due to resident #1's elopement. On . . . . . at 1:46pm Accompanied by the maintenance director to the Meadowbrook exit door. Resident #1 was observed at the door attempting to exit by pushing on the exit bar. After several attempts Resident #1 proceeded to turn and walk away from the door. The maintenance director proceeded to explain how the door works when resident #1 had	A 025		

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A 025	Continued From page 15 previously pushed on it. He states the door will slightly open coming off the hinge which provides a glimpse of light from the outside. He stated if the magnetic lock was off the door would open without sound allowing the resident to exit. On . at 1:47pm The maintenance director stated he was told Resident #1 had pushed on the exit doors 86 times in one day but was unable to state who had informed him. On at 2:58pm Staff D stated yes, I recall the event when Resident #1 eloped. Resident #1 likes to walk around and go into other resident's room. On that day, I gave resident #1 her medication and continued passing meds until 8:30pm. Staff D stated she started making rounds between 8:45pm-9pm. Staff D stated she went to resident #1's room as sometimes the resident's door is left open. Staff D stated, I did not see Resident #1, so I made another round of room checks and then notified the staff. I called the Director of Nursing and before I could call 911. 911 was calling me around 9 something asking if we were missing a resident. I replied yes. The EMT and officers checked resident #1 outside and returned to the facility at 9:15pm. Staff D stated the supervisor and maintenance director were called to check the doors. Staff D stated the staff check the doors all the time and there was no alarm or door slamming when resident #1 opened it. Staff D stated that night we did not expect her to leave. Staff D stated the residents are always being watched in the common areas. For Resident #1, I redirect her by offering snacks and drinks. Since the elopement, nothing has been put in place and	A 025		

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A 025	Continued From page 16 Resident #1 is allowed to continue to walk freely because the doors are locked. On - In review of Resident #1 progress notes the facility failed to document the elopement that occurred on or complete and incident report. On at 3:32pm The Administrator stated she was unaware resident #1 new 1823 did not indicate elopement risk or that it needed to continue as such being that she was placed on Hospice. On at 3:33pm The Administrator was made aware that resident #1 was observed times attempting to exit through the exit door located in Meadowbrook hallway unsupervised. The staff stated the concierge will notify each time this occurs and based on observation no staff made an attempt towards the exit door. On at 4:30pm The Administrator provided the facility's Certus Safety Elopement/Missing Resident Policy dated which states to prevent elopement Individual Service Plans will reflect elopement interventions for the safety of each resident. When resident returns to community, the Wellness Director shall arrange for a third-party, private duty companion to monitor the resident, shall conduct an assessment to determine whether the third-party, private-duty companion continues to be necessary, for two-weeks following the resident's return, caregivers shall conduct behavior monitoring to identify any triggers for another possible elopement, and caregivers shall update the resident's Individual Service Plan to reflect resident's high risk for elopement.	A 025		

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A 025	Continued From page 17 On at 4:30pm The Administrator stated I was not here at the time this occurred. I will need to go ask the Wellness Director if this was done. On at 4:34pm The Wellness Director stated I was unaware that was required that a third-party companion had to come in. After the Wellness Director reviewed the Elopement/Missing Resident Policy, she stated I looked, and I did not do an incident report on the elopement. The Wellness Director then confirmed that she did not follow the facility's policy on Elopement. On at 4:50pm The Administrator returned and stated I contacted Corporate because the Elopement Policy I provided earlier did not look right. The Administrator provided undated Addendum E Elopement policy. The Administrator agreed and confirmed the new policy provided did not change the fact the facility failed to follow their elopement policy. The facility's undated Addendum Elopement policy states Individual Service Plans will reflect elopement interventions for the safety of each resident. From time to time, all residents will be re-assessed for elopement risk. At a minimum of once per day, the Community caregivers shall ensure that all residents have identification on their persons that includes their name and the Community's name, address, and telephone number. Caregivers shall remain alert and follow re-direction techniques if a resident gains access to any exit areas. The Executive Director, along with other appropriate individuals, shall complete and incident report and notify the licensing agency per the licensing requirement.	A 025		

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A 025	Continued From page 18 Caregivers shall update the resident's Individual Service Plan to reflect resident's high risk for elopement. If physician deems it necessary to have a sitter, then an updated service plan shall be conducted. The Wellness Director shall evaluate the Community's continued ability to meet the resident's needs. 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 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	A 032		

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A 032	Continued From page 19 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: Based on observations, record reviews and interviews, the facility failed to make a daily effort to ensure 2 of 2 sampled residents who were identified as being at risk for elopement had	A 032		

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A 032	Continued From page 20 identification (ID) on their person that included their name and the facility's name, address, and telephone number (#1 and #2). Findings: 1. Review of resident #1's record revealed a facility admission date of . A 1823 Health Assessment indicates the resident's diagnosis was , communication , resides in the facility's secured memory unit and was not identified as an elopement risk. On at 9:43am Resident #1 was observed with no Identification on her person at the exit door North end hallway of Meadowbrook. The resident was standing at the door rubbing the exit bar unsupervised. The resident returned down the hall to the common area. Resident #1 was asked if she was attempting to exit, and the resident stated I don't know. Resident #1 was asked if she does this often and replied stating I don't understand what you're saying. On at 9:48am Caregiver B stated Resident #1 is always at the door, and she was never informed that resident #1 needed to be watched. On at 10:22am The Wellness Director stated I'm not aware of any residents who has eloped. On at 12:59pm The Administrator provided the case #23-11008 from the Orange County Sheriff. On the Orange County Sheriff's Report states, Resident #1 had slurred speech and could	A 032		

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A 032	Continued From page 21 not verify her name or address, or any other pertinent information. Therefore, additional deputies responded to the nearby group home for elderly people, and it was determined that Resident #1 had been missing from there. Further review of resident #1 record revealed it did not contain documentation to reflect the facility's staff made a daily effort to ensure resident #1 had ID on her person or routine safety checks performed by the caregivers. 2. Review of resident #2 record revealed a facility admission date of . A 1823 Health Assessment indicates the resident's diagnosis was adjustment with , periods of , resides in the facility's secured memory unit, and was not identified as an elopement risk. On at 9:27am Resident #2 was observed in the dining room with no Identification on his person. Resident #2 stated he had not attempted to leave and if he needed to, he would just inform the staff. A facility's note on at 13:03 states resident attempting to exit seek at this time to the front door. Resident exhibiting increased verbal aggression at this time. On at 9:48am Caregiver B stated she was aware of any residents eloping. On at 10:22am The Wellness Director stated I'm not aware of any residents who has eloped. On at 1:20pm The Maintenance Director stated, this is memory care and mostly	A 032		

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A 032	Continued From page 22 all the residents exit seeks. I only witnessed resident #2 attempting to exit 1 time during Sundowning. On . . . . . at 3:15pm Staff D stated yes, Resident #2 would try to get out. He gets upset and wants to go to his house outside of the community. Lately, he hasn't tried to get out. He tried to get out the front door in the town hall community. On at 3:32pm The Administrator stated she was aware that resident #2 1823 Health Assessment needed to reflect as elopement. Further review of resident #2 record revealed it did not contain documentation to reflect the facility's staff made a daily effort to ensure resident #2 had ID on his person or routine safety checks performed by the caregivers. The facility's undated Addendum E Elopement states, "Routine safety checks will be performed by caregivers. At a minimum of once per day, the Community caregivers shall ensure that all residents have identification on their persons that includes their name and the Community's name, address, and telephone number". On . . . . . at 4:35pm The Wellness Director confirmed that the facility did not follow their elopement policy. Class III	A 032		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service	A 081		

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A 081	Continued From page 23 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record.	A 081		

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A 081	Continued From page 24 (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in [illegible] control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its [illegible] control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to [illegible] borne [illegible], may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident [illegible],	A 081		

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A 081	Continued From page 25 neglect, and . . . . . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to obtain the staff in-service trainings for 1 of 3 sampled staff (A) within 30 days of employment as required. Findings:	A 081		

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A 081	Continued From page 26 1.Caregiver staff A's record review revealed hire date . A 2-hour certificate for pre-service orientation and all other required in-service trainings dated . There was no evidence of documented in-service trainings for: a) elopement training On at 4:52 PM, The Business Office Director confirmed the findings. Class III	A 081		
A 090 SS=D	59A-36.011(11) FAC Training - . . . . (11) . TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding . . within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure that one hour . . . . . ( ) training was completed for 1 of 3 sampled staff (A) within 30 days after employment.	A 090		

Agency for Health Care Administration

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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 090	Continued From page 27 Findings: Caregiver staff A's record review revealed hire date . . . . . There was no documented evidence of the 1-hour training was completed as required. On . . . . . at 4:52PM, The Business Office Director confirmed the findings. Class III	A 090		