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
	AL11968706	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT AVALON PARK	13798 CYGNUS DR ORLANDO, FL 32828

(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 A complaint survey #20230110210 was conducted on [redacted] at Encore at Avalon Park. The facility had a deficiency at the time of the survey.	A 000		
A 025 SS=D	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 [redacted] 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 observations, record reviews and interviews, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures for 1 of 4 sampled residents (#2). Findings: An interview with Nurse B on . . . . . at 3:08pm revealed the following: On at 3:08pm Nurse B stated, "she was paged on to come to the floor where resident #8 was located. Nurse B she was	A 025		

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A 025	Continued From page 2 informed that resident #8 was in resident #2's room and won't come out. Nurse B stated she saw resident #8 coming from resident #2's room. Nurse B stated she told the agency sitter you can't let resident #8 be more than 10 . . . away from you. Nurse B stated she has seen resident #8 chase the agency sitter with a fork. Nurse B stated she asked resident #2 if he was ok. Nurse B stated resident #2 said he asked resident #8 to leave his room. Nurse B stated resident #2 was upset because he could not stand up to defend himself because he's in a wheelchair. Nurse B stated I would have to tell the agency sitter to distract resident #8. We would take resident #8 to shower to try to calm him down from touching staff and the other residents. Nurse B stated resident #8 size makes him more intimidating. Resident #8 would take other residents' food. We have to give him double portions as he would eat his meals so fast. Nurse B stated during the 7p - 7a shift resident #8 was down the hall by the med cart. Nurse B stated I would have to put the med cart in between to keep resident #8 from touching me. Resident #8 beat up his female agency sitter overnight and tried to punch her. Nurse B stated resident #8 is . . . . with some of the ladies and they do not feel safe because of his size. A facility note on at 1:28pm read, "Resident #8 is very . . . . . and is not very easily redirected." A facility note on at 6:52pm read, "he (resident #8) is going into everyone's room and residents are panicking. He needs constant redirection."	A 025		

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A 025	Continued From page 3 A facility note on [redacted] at 9:41pm read, "resident #8 was [redacted] inappropriate with the caregivers." A facility note on [redacted] at 11:39pm read, "resident #8 behavior continues to need constant monitoring. Constant supervision required to keep resident from entering rooms of other residents and to keep him from [redacted] on floor in room and common area." A facility note on [redacted] at 10:54pm read, "resident #8 caught multiple times trying to molest and fondle another resident." A facility note on [redacted] at 12:41pm read, "resident #8 aggressive with staff, grabbing their arms when staff was trying to lead him to the bathroom, flailing at them and resisting direction. Combative with staff and refusing care. Squared up intimidating with another resident who met his aggression and resident swung at the other resident but hit caregiver in the arm. Rude and [redacted] inappropriate with residents and staff. Squeezed a female resident's [redacted] without consent. Takes excessive amounts of caregiver time to monitor to keep other residents safe." A facility note on [redacted] at 7:03pm read, "at approximately 4:50pm caregiver attempted to direct resident #8 out of another resident's room. Resident #8 pushed caregiver against the wall and elbowed him the right side abdomen." A facility note on [redacted] at 7:07pm read, "at approximately 5P resident #8 attempted to kiss a female resident. She held his [redacted] in an attempt to push him away and they began to struggle. No one was hurt."	A 025		

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A 025	Continued From page 4 A facility note on [redacted] at 7:00pm read, "at approximately 7:30pm, one of the caregivers tried to redirect the resident, the resident tried to punch caregiver in the arm and [redacted]." A facility note on [redacted] at 7:00pm read, "resident #8 very intrusive with staff and other residents, invading personal spaces and touching others, Resident #8 continually attempting to touch staff in ways that are inappropriate." A facility note on [redacted] at 4:16pm read, "resident #8 continues to be aggressive with staff, writer and sitter upon redirection to room x2. Resident #8 attempted to swing and punch writer in the [redacted], and resident tried to punch and hit caregiver in [redacted] and [redacted]. It took 5 staff members and sitter to calm resident #8 down enough to redirect to room." A facility note on [redacted] at 10:35am read, "resident #8 tried to inappropriately touch staff stating hey honey come sit on my [redacted], made racial gestures, walking around clinching his fist at residents and staff. Residents and staff are afraid of him. He is very unpredictable with his actions and moods." A facility note on [redacted] 12:46pm read, "resident #8 is very aggressive. He pushed one of the [redacted] against the wall this morning when taken [redacted] to his room to be changed and threw punches. At breakfast resident #8 was sitting next to one of the female residents and he was touching her and giving her kisses." A facility note on [redacted] at 6:54pm read, "resident #8 got into a fight with another male resident #11 in the evening after dinner on the [redacted] of trumpet."	A 025		

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A 025	Continued From page 5 On at 4:00pm Resident #11 stated he doesn't remember resident #8 or the incident. On at 4:00pm Resident #12 stated she knows resident #8 but he never tried to touch her. A facility note on at 6:49pm read, "resident #8 has a sitter with him, Resident #8 continues to be inappropriate and aggressive with staff and sitter when redirected. Multiple staff members and writer still continue to voice we are not safe with resident #8." A facility note on at 12:40pm read, "resident #8 woke up exhibiting behaviors, trying to grope caregivers." A facility note on at 12:40pm read, "resident #8 was very aggressive. Strike sitter in the with his fist multiple times. Tried to punch the nurse. Locked himself in bathroom multiple times." A facility note on at 7:47pm read, "resident #8 continued inappropriate behavior throughout shift, invading personal spaces of other residents and staff alike. Several residents voiced feeling uncomfortable around the resident with the continual intrusion." The facility's undated Grievance Policy states, "The Executive Director and Staff at Encore at Avalon Park strive every day to give the best possible care to each and every resident. We understand that you have placed your resident in our facility with the expectations that he/she will be cared for as if this were their home. We understand that despite the effort we put forth,	A 025		

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A 025	Continued From page 6 that a grievance might arise that will necessitate our immediate attention. Our entire staff has been made aware and received in-depth orientation with regard to the procedures involved in resolving any form of grievance to the satisfaction of all involved. The following has been adopted to address any grievances brought forth at Encore at Avalon Park. Within a 24 hour time frame, the Executive Director will review and discuss the content of the grievance with anyone directly involved and then will communicate a resolution to the resident's guardian or family member. Every effort will be put forth to resolve the grievance at this level. Documentation regarding the nature of the grievance and it's resolution, will be kept in a file in the Executive Director' office. A facility note on at 7:43pm read, "resident #8 continued with intrusive behaviors throughout the shift, invading the private space of other residents and staff alike. Continue the bother a female resident who expressed her discomfort and anguish with the residents behavior." A facility note on at 11:50pm read, "resident #8 per usual, constant redirection, and aggressive behaviors. Resident #8 knocks on all the residents doors in the middle of the night." A facility note on at 7:29pm read, "resident #8 sent to the hospital as per psych order to be posted on altercation with another resident. As the resident who was by resident #8, the resident came to his and his wife's apartment. The resident #2 stated, "I asked him to leave my room and he just closed the door, locked it behind him and started punching me in the ."	A 025		

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A 025	Continued From page 7 On at 4:38pm The third party agency stated,"We were contacted on to start services with resident #8 due to behaviors. We were hired for 24/7 care through ," On at 4:38pm The third party agency confirmed resident #8 did not have a sitter during the day on as resident #8's significant other requested night shift from 8:30pm - 8:45am. On at 4:55pm Agency caregiver G stated on resident #8 went to the door of resident #2 and pushed it fast. Caregiver G stated I tried to push the door, but couldn't get in. I called someone to come and open the door. Caregiver G stated I was walking behind resident #8 maybe a few behind him. Caregiver G stated, yes for the moment it was bad. Resident #8 tried to fight. He always try to fight other residents. I tried to prevent that and tell him not to do that. I try to talk to resident #8 and sometimes he listens or he just wants to walk. So, I walk with him and follow him. He only wanted to fight the men. Yes, he always wanted to touch the ladies, residents and staff. The facility's , Neglect, and , Policy dated states, "Encore is committed to maintaining a safe and -free environment for all residents and is committed to conducting a comprehensive investigation of allegations of activities or situations that may constitute . Corrective and preventive action to minimize recurrence will be developed and implemented on an individual, resident and facility basis. Outside entities, including regulatory agencies, Ombudsman, protective services, and legal investigators [i.e. police, etc]	A 025		

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A 025	Continued From page 8 will be notified and involved as appropriate to the situation. , : : unwanted activity, Identification: the facility will continue to monitor residents with needs and behaviors which might lead to conflict, or neglect, such as: Residents who are combative or enter other residents' room, Investigation: The executive director, administrator, and director of nursing will review and investigate all incidents reports." On at 4:10pm The administrator stated they are constantly putting interventions in place and changing resident #8 meds. On at 4:30pm The administrator stated, "we only have one incident report. Everything else is documented in the nurse notes. The administrator stated we don't do an incident report on every altercation. We did not issue resident #8 a 45-day notice. We called the POA and she stated she was on her way to another facility who did an assessment on him and stated if in a week he's stable they will take him. The administrator stated they requested male sitters from the third party agency. The administrator stated she did an assessment on resident #8 for move in and there was no aggression or anything on his 1823 health assessment about his behaviors. On review of resident #8 residency agreement states, on page 2 Discharge, provide at least forty five (45) days written notice of termination of residency from Encore at Avalon Park unless, the resident becomes a danger to himself or others; or engages in a pattern of conduct that is harmful or offensive to other residents.	A 025		

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A 025	Continued From page 9 On . . . . . at 5:13pm The administrator stated they did not notify DCF when resident #8 hit the third party agency caregiver. The administrator stated they kept resident #8 from the other residents until they had a sitter. The administrator stated we have to wait to see what the hospital says, we don't want to bring him On . . . . . at 10:12 am, resident #2 said that last week resident #8 entered resident #2's room and beat him on his . . . . Resident #2 said he did not suffer injuries as a result. He said it was the first and last time it happened, and he believed resident #8 no longer lived at the facility. Class III	A 025		