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
	AL11968966	A. BUILDING: _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTRY PARK ORLANDO	3201 CENTER POINT DR 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 000	Initial Comments A complaint investigation #2023017771 was conducted on [redacted] at Gentry Park Orlando. A deficiency was found at the time of the visit.	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 [redacted] 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 [redacted] or [redacted]. 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 [redacted] 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.	A 025		

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A 025	Continued From page 1 (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, observations and interviews the facility failed to maintain a general awareness of a resident's whereabouts and supervise as appropriate for 1 out of 4 residents (#1) and failed to provide adequate supervision to prevent that resulted in an injury for 1 out of 4 residents (#2). Findings: 1. In a review of resident's #1 health assessment dated it revealed the following medical history: Wedge of 1st and 2nd , Type II , , , and , alert with , ambulates with walk and assistance	A 025		

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A 025	Continued From page 2 and requires assistance with daily living to include eating, self-care, transferring, ambulation, bathing, [illegible], toileting. Resident resides in the memory care unit, and she is not an elopement risk. Resident was observed on [illegible] in the memory care unit in the common area at 11am. She was alert with some [illegible]. She did not have an identification bracelet on her person. In an interview on at 10am with resident#1's family member, he confirmed that there was an arrangement with the facility that resident#1 is to have meals and some activities on the assisted living side of the facility. He stated he was informed of the elopement by the facility but assumed when resident#1 was taken out of the memory care unit for meals and activities that she would be supervised at all times. In a review of facility records dated , it states the resident#1 resides in memory care area of the facility attending activities. When a 3rd party [illegible], was looking for the resident for her , , , she noticed the resident walking towards the building from around the other side and escorted her into the building. The resident had left the building through the front door, at the time the receptionist was not at the reception desk. The resident was last seen at activities around 11am and was found walking outside in the front of the building from around the other side. In a review of the facility's elopement policy is defined as a resident with diagnosis of [illegible], physically, mentally emotionally and or chemically [illegible] leaves a caregiving environment unnoticed or unsupervised.	A 025		

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A 025	Continued From page 3 In an interview on at 10am with resident#1's family member, he confirmed that there was an arrangement with the facility that resident#1 is to have meals and some activities on the assisted living side of the facility. He stated he was informed of the elopement by the facility but assumed when resident#1 was taken out of the memory care unit for meals and activities that she would be supervised at all times. In an interview on at 11:15am Staff F Stated resident #1 goes to dining and activities on the assisted living side as she used to live there and is independent. She stated a staff from memory care unit will wheel her over to the assisted living side and then a care person on the assisted living side will radio when resident#1 is ready to come . . . to the memory care unit. She stated she assumes someone on the assisted living side is supervising her until she comes . She stated resident#1 is not considered an elopement risk. In an interview on . . . . . at 11:30am Staff G stated the care staff brings resident#1 over to the assisted living side for activities and dining. She stated the activity person or care staff on the assisted living side supervises her and then radios us on the memory care side when she is ready to come . . . . She stated she assumes the assisted living side staff is aware the resident resides in memory care and supervises her while she is over on the assisted living side. She stated resident#1 is not an elopement risk. In an interview on . . . . . at 12:10pm with resident#1, she stated she was not aware she could not just go outside by herself, and she would not do that again. She stated she	A 025		

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A 025	Continued From page 4 understands now that staff must be with her at all times when she is over on the assisted living side of the building, and she will be accompanied by staff if she wants to go outside. 2. In a review of resident#2's health assessment dated , it revealed a medical history of , , , , , rhabdomyolysis. She requires assistance with daily living to include supervision with eating and self-care. She needs assistance with ambulation, bathing, , toileting and transferring and she is a risk. Resident#2 resides in the memory care unit and is not an elopement risk. In an observation on at 12pm, resident#2 was at the dining table in memory care and observed with no marks or , however she had a small knot on the top of her forehead. She was nonverbal and appeared she was only oriented to herself. An observation of her room did appear to have hazards for . In a review of the facility's records, it confirmed the resident had unwitnessed on , , and . In further review on a resident was in the dining area in memory care when a staff member noticed the resident had a large, raised bump on her forehead that had been covered by her hair. The resident was sent to the hospital for evaluation. The hospital indicated that they discovered 4 , deformities, the T8 , is acute, and an orthopedic doctor was recommended. In a review of resident#2's facility's care plan dated the resident requires assistance with transfers to get out of bed, chair etc. initiated . Behaviors observed for elopement risk	A 025		

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A 025	Continued From page 5 and [redacted], remind resident to inform staff immediately if they have a [redacted]. Encourage resident to stay in common areas to promote more supervision. Remove any potential causes for hazards, educate resident of potential hazards. There were no progress notes or log of the 72 hours post incident on [redacted]. In a review of the facility's [redacted] policy, it states a [redacted] assessment will be conducted prior to admission, at admission and during each required assessment, after a [redacted] and after a significant change. When a resident [redacted], charting in the resident's progress notes or a 24-hr. log will be done every shift for 72 hours post incident. Assure resident is reassessed, appropriate supervision and interventions are in place, and follow up completed. Assure the service plan is updated. In an interview on [redacted] at 11am with the director of nursing, she stated the staff follows the care plan to ensure there are no hazards, inform resident she must call for assistance when she wants a shower or get dressed or transferring. She stated resident#2 likes to do things on her own and she often does not call for assistance. She stated since last [redacted] in [redacted] the resident is supervised more frequently now, she is reminded to call staff and she has not had a since. She stated only the nurse charts the progress notes and they should have logged the progression. In an interview on [redacted] at 1pm with the administrator, he confirmed the findings above. Photographic Evidence Obtained Class III	A 025		

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