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
	AL11966519	A. BUILDING: _____ B. WING _____	02/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBIANCE AT MAITLAND	740 NORTH WYMORE ROAD MAITLAND, FL 32751

(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 re-licensure survey, a Complaint Investigation #2023018444 and a generator monitoring was conducted at Ambiance at Maitland Assisted Living Facility on [redacted]. The facility had deficiencies at the time of the survey visit.	A 000		
A 004 SS=D	59A-36.004 FAC Licensure - Requirements 59A-36.004 License Requirements. (1) SERVICE PROHIBITION. An assisted living facility may not represent that it provides any service other than a service for which it is licensed to provide. (2) CHANGE IN USE OF SPACE REQUIRING AGENCY CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility's capacity must not be made without prior approval from the Agency Central Office. Approval must be based on the compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection requirements referenced in Rule 59A-36.005, F.A.C. (3) CHANGE IN USE OF SPACE REQUIRING AGENCY FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, must not be made without prior approval from the Agency Field Office. Approval must be based on compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection standards referenced in Rule 59A-36.005, F.A.C. (4) CONTIGUOUS PROPERTY. If a facility consists of more than one building, all buildings included under a single license must be on	A 004		

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A 004	Continued From page 1 contiguous property. "Contiguous property" means property under the same ownership separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of Chapters 408, Part II, 429, Part I, F.S. and rule Chapter 59A-35, F.A.C., and this rule chapter. (5) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in Rule 59A-36.005, F.A.C., must be submitted annually to the Agency Central Office. The annual inspections must be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result in administrative action pursuant to Chapter 408, part II, and Section 429.14, F.S., and rule Chapter 59A-35, F.A.C. (6) RESIDENTS RECEIVING STATE-FUNDED SERVICES. Upon request, the facility administrator or designee must identify residents receiving state-funded services to the agency and the department for monitoring purposes authorized by state and federal laws. This Statute or Rule is not met as evidenced by: Based on observation, facility's documentation and interview, the facility failed to notify the Agency for Health Care Administration (AHCA) before changing use of space that required renovation & construction to both Memory Care and Assisted Living Facility licensed buildings in which had not been inspected previously for such use; and the facility failed to obtain approval from the Field Office and Central Office approvals with AHCA to ensure compliance as required. Findings:	A 004		

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A 004	Continued From page 2 Observation on at 9 AM, the Assisted Living Facility (ALF) was under renovation and construction. There were no residents inside the building, and it was closed to the public. It was asked of the construction worker that was sitting in the dark where were the residents at? He answered that they moved to the Memory Care building. Observation on at 9:05 AM, the Memory Care had brand new renovations and construction completed. The use of space had been changed from the original and previous floor plan. There was a census of 36 residents. The capacity for both buildings was 116 total. On at 9:45 AM, an interview with the Administrator to provide documentation that the agency was notified about the renovations and construction with change of use in space. Furthermore, it was requested to provide a list of the residents that was discharged from the Assisted Living since that building was closed. The Administrator stated that most of the residents of Assisted Living were given 45 days' notice and moved to nearby assisted living facilities or moved home with family. A review of an email dated at 6 PM to the Assisted Living unit in Headquarters Tallahassee attaching a copy of the fire inspection report and documented that the Assisted Living building was currently under construction/renovation with no residents in it. This was the only documented evidence provided to the agency that the facility reported of the change in use of space, construction, and renovation. Memory Care had already completed	A 004		

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A 004	Continued From page 3 change of space, construction, and renovation some time ago. The administrator could not confirm exactly the date of completion because she had just started employment in , A review of the 45-day notices to the residents that lived in the Assisted Living dated to a total of 26 residents provided by the administrator. The majority of the 45-day notices were emailed to residents and/or legal representatives. In addition, an admission and discharge log for the location of each 26 residents that had relocated or moved. (Photographic Evidence Obtained) On at 2:30 PM, an interview with the Administrator confirmed the findings, and further stated that she had no other documentation to provide where the facility had notified the AHCA agency, the Field Office and the Central office prior to the renovation and construction before Class III	A 004		
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	A 032		

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A 032	Continued From page 4 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: 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	A 032		

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A 032	Continued From page 5 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 review of the facility's documented elopement drills, personnel record reviews and interviews, the facility failed to have documentation that 2 of 4 sampled staff participated in a minimum of two resident elopement drills each year (A & C). Findings: Review of personnel records revealed Staff A hire date was ..... and Staff C hire date was on . On at 2:45pm The Maintenance Director stated he did not have the drills for 2022, 2023, and was unable to locate the binder. On at 3:00pm The Maintenance Director provided the resident elopement drills. Review of the , , , and ..... revealed no documentation whether Caregiver A or caregiver C participated in elopement drills. Class III	A 032		