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
	AL11969943	A. BUILDING: _____ B. WING _____	R 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE AT TRELAGO THE	901 VISTA TRELAGO 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 revisit to the a re-licensure survey was conducted at The Grove at Trelago on . The facility had uncorrected deficiencies at the time of the visit.	{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 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	A 010		

AHCA Form 3020-0001

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

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A 010	Continued From page 1 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 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.	A 010		

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A 010	Continued From page 2 (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 [illegible]-to-[illegible] 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) 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], [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	A 010		

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A 010	Continued From page 3 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , 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. (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.	A 010		

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A 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on resident record review and interviews, 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 1 of 1 sampled resident (#14) as required in an assisted living facility (ALF). Findings: On [redacted] a review of the Incident Report dated [redacted] stated an event reported to law enforcement and resident elopement. On [redacted] at 4:10pm review of Resident #14's record revealed a facility admission date on [redacted]. A [redacted] Health Assessment Form indicated a medical history of [redacted], Lewey Body [redacted] and was not identified as an elopement risk. A facility note on [redacted] at 11:18 read, "Resident taken to another facility this morning for a respite stay until a memory care bed is available at the community at The Grove." A facility note on [redacted] at 11:04 read, "Episode this morning where Resident #14 called the police and told them that he was going to be assassinated and that he was being held prisoner." A review of the Maitland Police Event Report # 20240901336 dated [redacted] indicated arrived at 13:01 to the facility, subj has [redacted], w/m burgundy shirt and tan shorts. The event cleared at 13:25.	A 010		

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A 010	Continued From page 5 A facility note on . . . . . at 16:53 read, "A search team was implemented right away in the community and outside. Resident was found and brought to the community by the police officers of Maitland around 1:20pm. 15 min checks were implemented to keep residents safe in the community." A facility note on . . . . . at 18:38 read, "Resident seen with wife outside of the front of building. The wife reports resident wrote her a note, and showed this nurse a piece of paper with a message from resident that he was going for a walk. Resident redirected into building with wife." A facility note on . . . . . at 2:45 read, "Resident was found going out of the facility . . . . . . The resident was brought . . . to the room by med tech without difficulty." A review of Resident #14's Task List Report stated on . . . . . Resident is one to one with private aide 24/7. On at 6:20pm The Director of Nursing stated after being asked if Resident #14's doctor was notified of the change in condition, "Honestly, I really didn't think about it. I was just concerned with keeping him safe." The facility's Elopement Policy dated stated, "To assess and identify at-risk Residents for Elopement 30 days prior to or at time of admission and evaluated regularly after admission to prevent future Elopement. Consideration by the physician should be requested regarding if the need for medical or . . . . . re-evaluation."	A 010		

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A 010	Continued From page 6 (Photographic Evidence Obtained) On [redacted] at 6:45pm The Director of Nursing confirmed the findings. 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 [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 025}		

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{A 025}	Continued From page 7 (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 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 adequate supervision to 1 of 1 sampled resident who eloped from the facility by maintaining a general awareness of the resident whereabouts and emotional general well-being (#14). Findings: On . . . . . a review of the Incident Report dated stated an event that is reported to law enforcement and resident elopement.	{A 025}		

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{A 025}	Continued From page 8 On . . . . . at 4:10pm review of Resident #14's record revealed a facility admission date on . . . . . . A . . . . . Health Assessment Form indicated a medical history of Fib, Ataxia, , , ... , ... , Lewey Body and was not identified as an elopement risk. A facility note on . . . . . at 11:18 read, "Resident taken to another facility this morning for a respite stay until a memory care bed is available at the community at The Grove." A facility note on at 11:04 read, "Episode this morning where Resident #14 called the police and told them that he was going to be assassinated and that he was being held prisoner. Private aid remains in the room with Resident #14 at this time." A facility note on . . . . . at 14:09 read, "Resident calm and pleasant. Reminders given to call for assistance as needed. Private aide and wife at side. No exit-seeking behavior noted." A facility note on at 17:26 read, "Private aide and wife by his side. Pleasant and calm." A review of the Maitland Police Event Report # 20240901336 dated . . . . . indicated arrived at 13:01 to the facility, subj has , w/m burgundy shirt and tan shorts. The event cleared at 13:25. A facility note on at 16:53 read, "Unlicensed Caregiver E told resident she was going to be to his room to help him with a shower. Unlicensed Caregiver E went to resident room around 12:11 and couldn't find	{A 025}		

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{A 025}	Continued From page 9 resident in his room. Care Staff had to come downstairs to look for him in the community. The front desk last had seen resident sitting on the bench at the entrance of the community about 11:47am. A search team was implemented right away in the community and outside. The care team made sure all rooms were checked after which 911 was called at 12:52pm. Resident was found and brought to the community by the police officers of Maitland around 1:20pm. 15 min checks were implemented to keep residents safe in the community." A facility note on at 18:38 read, "Resident seen with wife outside of the front of building. The wife reports resident wrote her a note, and showed this nurse a piece of paper with a message from resident that he was going for a walk. Resident redirected into building with wife." A facility note on at 2:45 read, "Resident was found going out of the facility . The resident was brought to the room by med tech without difficulty. Upon last check resident was in bed sleeping." A facility note on at 15:39 read, "Move-in Note, white male arrived via transport with family." A review of Resident #14's Elopement Risk Assessment e-signed and dated by the Director of Nursing (DON) on "indicates a category of high risk with a score of 12. Resident #14's assessment revealed the resident has a diagnosis of , , and . The resident has medications that increase restlessness, agitation, and a history of elopement, off, and getting lost. The	{A 025}		

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{A 025}	Continued From page 10 document stated if the score is 5 or greater, they are at risk." A review of Resident #14's Elopement Risk Assessment e-signed and dated by the DON on "indicates a category of high risk with a score of 15. Resident #14's assessment revealed the resident has a diagnosis of , , and . Indicates, yes, the resident pace, , try to get out of door, try to find family or friends, perceive they need to be doing something other than what they are doing. The resident has a history of elopement, off, and getting lost. The document stated if the score is 5 or greater, they are at risk." On at 5:22pm an attempt was made to speak with Resident #14's wife regarding his behavior. A review of Resident #14's Task List Report stated on every 4 -5 safety checks were initiated. A review of Resident #14's Task List Report stated on Resident is one to one with private aide 24/7. On at 5:48pm Unlicensed Caregiver E was contacted to follow up on Resident #14's elopement on . On at 6:20pm The DON stated, "Resident #14 was very passive and usually stayed with his wife around the facility. Yes, we did an assessment on admission and there were no prior attempts of him . The DON was asked what was put in place after Resident #14 was identified as from the facility	{A 025}		

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{A 025}	Continued From page 11 two days after admission? The DON stated we were doing checks every 4 hours, so if you think of it, it's more after meals when he needed redirecting. The DON was asked why 2 hours checks were not conducted? The DON stated, its every 4hours not 2. After the first attempt, I did not feel there needed to be a change in the safety checks for him." On at 11:23am The Memory Care Director J stated during a phone interview, " I did the search with the staff and Nurse F called the police. I was notified at the manager's meeting of his prior attempts to elope. I was notified on that Saturday as I was the Manager on Duty (MOD) that the staff went to look for him in his room and he was not there. No, he did not have a sitter at that time. The wife had gone out with a friend. When the staff went to check on him, he was not there. They went to the dining room, and he was not there. The front desk concierge was shown his picture and stated oh he was up here. We then started looking for him and after 20-25 minutes he was not found. We then called the DON to notify her and called the wife to determine if he was with her. The wife stated he was not with her. The sitter was put in place after the police returned him to the facility. I don't know if he had any ID on him in his wallet. "No, he did not have a facility ID bracelet on him with his name or the facility's name and address." On at 11:56am Kitchen Staff G stated during a phone interview, " I was arriving to work that day as I work in the kitchen. I saw Resident #14 standing at the fountain. No, he didn't seem as though he was , and nothing seemed usual. It was normal for the residents to go outside and stand around the fountain. I had no prior knowledge of the resident attempting to	{A 025}		

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{A 025}	Continued From page 12 leave the building." On . . . . . at 12:00pm Kitchen Staff H, the dining manager stated during a phone interview, "I saw him at breakfast between 8-9am. When I returned from break, I saw him at the fountain around 11am. I didn't really talk to him. A lot of the residents tend to walk around the building on the sidewalk and he was walking towards the . . . of the building. I explained to the staff that I saw him at the fountain. I jumped in my car and started driving to the building to look for him up in the . . . on the winding road that leads to the apartments. I walked around the building as well. I ran into a couple of the care staff, and they stated they found him." On at 12:25pm Unlicensed Caregiver E stated during a phone interview, "Resident 14's wife had just left with a friend, and I told the other staff that we had to watch him because he will try to leave with the wife. I left to go shower another resident and when I returned, I saw he was not in his room. I asked the other staff if they had seen him, and they said he was in the dining room. When I went to the dining room, he was not there, and I notified the MOD that he was not in the dining room and that we needed to look for him. All the staff, including kitchen staff started to search around the property and in all the rooms. Then after . . . minutes we called the police. Resident #14 did not have an ID bracelet on him with his name or the facility's name and address identifying him as an elopement. We did another elopement training after he was found and returned to the facility. The family hired a 24-hour sitter, and they came within the next hour after being notified. Prior to that day, I was told we had to keep watch by the other staff overnight. No, the DON did not tell us to watch him. We started	{A 025}		

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(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 025}	Continued From page 13 doing 15 to 30 minutes checks. We just took it upon ourselves due to an intuition that he needed to be watched more based on his prior attempts to leave. We did not document anything, and the nurses were aware of that." On [redacted] at 1:23pm Nurse F stated during a phone interview, "That day he eloped, he had a [redacted] on his [redacted], and I was called in to change the [redacted]. After that, he was supposed to take a shower. I left to go do meds on the other side of the building. After that, it was determined that he was missing. We started searching for him in all the rooms and in the community. After that we went outside and then I called 911. I was aware of him [redacted] before this day. The people at the front desk were aware that he was a [redacted]. I'm not aware of Resident #14 having the elopement ID on him. He was not identified as an elopement risk. The staff upstairs continued to monitor him every 15 minutes after the event along with the private sitter. The DON was notified when he eloped, and she came up to the premises. We did the assessment together on Resident #14 after he was found outside of the property and the cops had to bring him [redacted]." On [redacted] at 2:54pm Kitchen Staff I stated during a phone interview, "I saw Resident #14 by the fountain when I was coming in to work. It was not a red flag when I saw him outside. He didn't seem [redacted] based on what I could tell. I didn't know he was an elopement risk as I am a kitchen staff. I found out after he was brought [redacted] that he had eloped. On [redacted] at 6:45pm The Director of Nursing confirmed the findings. Class II	{A 025}		

Agency for Health Care Administration

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	AL11969943	A. BUILDING: _____ B. WING _____	R 04/23/2024

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{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 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.	{A 032}		

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{A 032}	Continued From page 15 (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 record reviews and interviews, the facility failed to make a daily effort to ensure 1 of 1 sampled resident who was identified as being at risk for elopement and had identification (ID) on their person that included their name and the facility's name, address, and telephone number (#14). Findings: On a review of the Incident Report dated . . . . . stated an event that is reported to law enforcement and resident elopement. On at 4:10pm review of Resident	{A 032}		

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{A 032}	Continued From page 16 #14's record revealed a facility admission date on . A Health Assessment Form indicated a medical history of , Ataxia, , , , , Lewey Body and was not identified as an elopement risk. Further review of the resident's record revealed it did not contain documentation to reflect the facility's staff made a daily effort to ensure resident #14 had ID on his person. A facility note on at 11:18 read, "Resident taken to another facility this morning for a respite stay until a memory care bed is available at the community at The Grove." A facility note on at 14:09 read, "Resident calm and pleasant. Reminders given to call for assistance as needed. Private aide and wife at side. No exit-seeking behavior noted." On at 6:20pm The Director of Nursing (DON) stated, yes, Resident #14 had ID on him with his name, facility's name, and address. After the first attempt, I did not feel there needed to be a change in the safety checks for him. No, we didn't document anything. I was just concerned with keeping him safe." A review of Resident #14's Elopement Risk Assessment e-signed and dated by the Director of Nursing (DON) on "indicates a category of high risk with a score of 12. Resident #14's assessment revealed the resident has a diagnosis of , , and . The resident has medications that increases restlessness, agitation, and a history of elopement, off, and getting lost. The document stated if the score is 5 or greater, they	{A 032}		

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{A 032}	Continued From page 17 are at risk." A review of Resident #14's Elopement Risk Assessment e-signed and dated by the DON on "indicates a category of high risk with a score of 15. Resident #14's assessment revealed the resident has a diagnosis of , , and . Indicates, yes, the resident pace, , try to get out of door, try to find family or friends, perceive they need to be doing something other than what they are doing. The resident has a history of elopement, , off, and getting lost. The document stated if the score is 5 or greater, they are at risk." The facility's Elopement Policy dated stated, "To assess and identify at-risk Residents for Elopement 30 days prior to or at time of admission and evaluated regularly after admission to prevent future Elopement. The Resident and Family will be interviewed to determine level and history of Elopement. At risk Residents, will be identified for Staff to be alerted to their needs for support and supervision. The at-risk Resident will be provided with identification that includes the Residents name, the facility name, address, and phone number. Staff will make a daily effort to ensure that Resident have identification on their person. Consideration by the physician should be requested regarding if the need for medical or re-evaluation." On at 11:25am The Memory Care Director J stated during a phone interview, No, he did not have a facility ID bracelet on him with his name or the facility's name and address." On at 12:25pm Unlicensed Care Staff	{A 032}		

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{A 032}	Continued From page 18 E stated during a phone interview, "Resident #14 did not have an ID bracelet on him with his name or the facility's name and address identifying him as an elopement. Prior to that day, I was told we had to keep watch by the other staff overnight. No, the DON did not tell us to watch him. We started doing 15 to 30 minutes checks. We just took it upon ourselves due to an intuition that he needed to be watched more based on his prior attempts to leave. We did not document anything, and the nurses were aware of that." On . . . . . at 1:23pm Nurse F stated during a phone interview, "I was aware of him before this day. The people at the front desk were aware that he was a . I'm not aware of Resident #14 having the elopement ID on him. He was not identified as an elopement risk." On at 4:24pm The Director of Nursing was contacted by phone and confirmed the findings. Class III	{A 032}		