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
	AL11965048	A. BUILDING: _____ B. WING _____	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AT OVIEDO	1725 PINE BARK OVIEDO, FL 32765

(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 Two Complaint investigations #2023018610 and 2024000169 were conducted at Madison at Oviedo. A deficiency was identified at the time of the visit.	A 000		
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 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		

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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 interviews, observation, and record review the facility failed to provide adequate supervision to ensure safety through proactive measures to minimize the potential for elopement for 1of 2 sampled residents (#1). Findings: In a record review of resident#1's health assessment dated [redacted] and an admission date of [redacted], revealed a medical history of [redacted], and diminished hearing. It also states the resident was independent of assistance with daily living, needed assistance with medication and was not an elopement risk at	A 025		

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A 025	Continued From page 2 the time admission. In a review of the facility observation notes it stated the following: . . . . . Resident asking to go home. No attempts to leave the building today. . . . . . Resident continues . . . . and exit seeking behaviors. Redirection often. . . . . . Resident observed by staff attempting to open car doors in the parking lot at 8:15am. Resident redirected . . . into facility. Fire dept called at 1637 regarding resident that she was found . . . . Slavia Road, Oviedo (1 from facility) with some personal belongings such as sweaters, remote control, and her keys. Resident was found and returned to the facility by the fire department. Residents were then placed in memory care unit and family was notified. Family, physician, and facility agreed to have resident permanently remain in memory care. The last time the resident was seen was at breakfast. In a review of the facility's elopement policy, it states it is defined as a person who is . . . . leaves the community without staff knowledge or supervision, lacks safety awareness cannot distinguish their safety needs or has , appropriate decisions making ability. In an interview on . . . . . at 11am with another state agency revealed the family informed her that their mother would . . . . when living at home, but they never mentioned that to the facility because they didn't want to pay for the memory care unit. In an interview on at 12pm with the	A 025		

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A 025	Continued From page 3 business office manager, she confirmed the incidents and stated the resident is now residing in the memory care unit. In an interview on at 1:15pm Staff G stated the staff tries to keep the residents busy, so they do not or have issues. She stated resident#1 has not displayed any exit seeking behaviors since residing in the memory care unit. She stated she is a very good resident and very pleasant to be around. She stated she completed an elopement drill last month on the 1st shift. In an interview on at 1:45pm Staff I stated resident #1 did not show any exit seeking behaviors while residing on the assisted living side. She stated she did hear about her in the parking lot and eloping from other staff. She stated when we have an exit seeking resident, we always try to keep them busy during the day. She stated she completed an elopement drill last month on the first shift. In an interview on at 2pm with resident#1's power of attorney, he stated he was not aware that his mother had exit seeking behaviors. He stated the facility made him aware of the two other times she had exit seeking behaviors prior to the elopement on . He explained he felt that was because she was in a new environment and wanted to go home. He stated he agreed with the facility after the incident of elopement that she would be safer in the memory care unit. Class II	A 025		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other	A 152		

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A 152	Continued From page 4 (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by:	A 152		

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A 152	Continued From page 5 Based on record review and interview the facility failed ensure all staff (3rd shift) received appropriate training (fire drills) for emergency procedures. Findings: A request was made for a record review of documentation of staff fire drills 2023 and 2024. The facility did not have documentation of the overnight 3rd shift participated in any fire drills. In an interview on [redacted] at 11:00am with the maintenance director, he confirmed he is in charge of doing the fire drills with staff. He stated he has not completed any this year. He stated he does not like to sound off the alarm in the middle of the night and wake up the residents. He stated he has no documentation of the drills he has completed last year. In an interview on at 11:30am Staff D confirmed she works the overnight shift and stated she did an elopement drill with the administrator [redacted] in [redacted]. She stated she does not remember the maintenance person doing a fire drill this year, but she is new here. She stated she has not done a fire drill this year yet. In an interview on [redacted] at 11:45am Staff E confirmed she works the overnight shift and stated she completed elopement drills last month but not fire drills. She stated last month the maintenance manager came in the facility on the overnight shift and just had the overnight shift sign a piece a paper saying we completed a fire drill without actually having one. She stated we all signed even though there was no drill at all.	A 152		

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A 152	Continued From page 6 In an interview on . . . . . at 12pm with the business manager, she confirmed the findings. Class III	A 152		