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
	AL11910126	A. BUILDING: _____ B. WING _____	R 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(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 survey to complaint investigation #2024003026 and 2024003725 was conducted at Grand Villa of Altamonte Springs on . The provider had a deficiency 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 … … … 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	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 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 observations, 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. (#7). Findings: Observations of camera footage on revealed Resident # 7 exiting the Assisted Living 100 building at approximately 3:03am on	A 025		

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A 025	Continued From page 2 A review of an incident report dated [redacted] stated the resident elopement and was transferred to a more acute care due to the incident. A record review of resident #7 revealed a facility's admission on [redacted] A [redacted] 1823 Health Assessment indicated a medical history of [redacted], Type 2 [redacted], [redacted] & collapse, [redacted] [redacted] prostatic hyperplasia, and was identified as an elopement risk. A facility note on [redacted] at 11:45am read, "per camera footage, resident leaves his apartment around 2:50am and is redirected [redacted] into his apartment. Resident proceeds to walk [redacted] out of his apartment and walks around the building's first floor. Resident walks out of the main entrance and walks down the ramp and turns [redacted] around; resident does this a couple of times before walking towards the community's main entrance on orange drive around 3:11am. The resident was at Burger King, behind Grand Villa, when [redacted] was called due to a [redacted]. The resident was transported to Advent Health Altamonte for further evaluation. Resident was not admitted and returned to the community a few hours later. ED spoke with POA about moving resident to the memory care neighborhood for his safety. Resident was moved to memory care that same afternoon." A facility note on [redacted] at 2:00pm read, "writer received a phone call via the on-call phone at approximately 6:40a that this resident had left the community without signing out. [redacted] then called and stated the resident had a [redacted] at Burger King restaurant next to the community. Resident	A 025		

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A 025	Continued From page 3 was transported to Advent Health Altamonte for evaluation." A facility note on at 11:45am read, "I checked resident at 9am resident sugar was 419, Doctor was notified and ordered STAT work." A facility note on at 1:00pm read, "Per provider orders writer to check residents q20 mins x3. Readings are as follows: 1qt =308, 2nd = 328, 3rd = 318." A facility note on at 11:30am read, "Resident is 433. Writer contacted provider. Provider ordered one time 15 units of STAT. Provider also order bloodwork and f/u q20 mins x 3." A pre-determination assessment dated in Resident #7 chart stated, "early to rise 5am and early to bed 8pm." On at 12:54pm Nurse F stated, "yes, I documented Resident #7's on . Yes, it was high, so I contacted the doctor, and he ordered the 15 units of . No, Resident #7 gets his checked every morning at 9am. I was not here the day Resident #7 left but I heard about it. The days prior he did not have any changes in his behavior. He stated he was fine." On at 1:08pm Resident #7 was observed in his memory care room. Resident appeared alert, oriented, and was wearing a purple ID bracelet with his name, facility's name, and address. Resident stated, I don't know why I left the facility that night. No, the staff did not try to get me to go into the room and I never	A 025		

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A 025	Continued From page 4 saw her. Resident #7 stated, "they ordered this bracelet for me and told me not to take it off. So, I didn't." On . . . . . at 1:20pm the Administrator stated, "Resident #7 walked out the front door. The door does not lock from the inside. The door has an alarm when it's opened after hours. However, if the staff does not hear or have the walkie talkie on, they will not here the alert stating door to 100 activated. The Administrator stated, yes, I have the video and you may review it. It will show the resident attempting to leave his room and the staff telling him to go . Once he goes . . . , the staff goes into another resident's room next to resident 7. Resident #7's room is right by the elevator. He leaves the room again and goes to the elevator. Afterwards, he goes downstairs and after several minutes he goes out the front door. You will see in the video once he goes out the door down the ramp, he comes . . . looks in the door and then turns heading down the ramp into the parking lot and that's where the video loses him." On at 1:57pm unlicensed staff care G stated, "when Resident #7 was out of his room. I was trying to figure out where he was going. It's not like him to be up that early. I did not know if he was sleepwalking. Another resident's pendant went off and I went to check it. Resident #7 was still standing in his doorway, and I asked him to go . . . into his room. I did not stay and watch him. After I came out of another resident's room, he was still standing there. As I was walking away, I went to the bathroom and didn't take my walkie talkie. When I passed meds at midnight to Resident #7's roommate. Resident #7 was asleep and always sleeps through the night. When I was getting up to do my rounds at 5am, I	A 025		

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A 025	Continued From page 5 asked his roommate if Resident #7 was in here. I realized he was not in the building. I started looking for him and reached out to other staff to make them aware. As we were looking someone from another building told me on the walkie talkie that the hospital was calling. I contacted the Administrator once I had all the information and then contacted Resident #7's emergency contact on file. On . . . . . at 3:18pm the Administrator stated, "unlicensed care staff G told me she was in the bathroom and left the walkie talkie on the desk. I'm working with the monitoring company who covers our walkies and pendants on getting a door lock to add an egress which will cause the door to alarm once pushed after hours and the alarm will continue until the alarm is turned off." at 3:45pm the Administrator confirmed the findings and stated he will provide a copy of the video. Class II	A 025		