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
	AL11965334	A. BUILDING: _____ B. WING _____	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF WINTER SPRINGS	1057 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 (#2024007197) and generator monitoring were conducted on at Arden Courts, Winter Springs. A deficiency was found 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		

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 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, observations and interviews the facility failed to maintain general awareness of resident's whereabouts resulting in elopement for 2 out 3 residents (#1 & #2). Findings: 1. In a record review of resident#1's confirmed an admission date of and a health assessment dated . The resident's health assessment confirmed a medical history of , paranoia, mild , assistance with medications and independent of assistance with daily living. It also revealed the resident was an elopement risk and a history of	A 025		

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A 025	Continued From page 2 . The resident resided in the memory care unit at the time of the incident as a respite resident. In a review of resident#1's daily observation notes revealed the following: On at 10:10am resident was observed in the parking lot by a staff person as she was moving her car. Resident was brought into the community. Upon investigation and gathering statements, it was learned resident#1 knocked on the memory care door from inside of the memory care unit and the administrative assistant opened the door and let the resident through the memory care door and out the front door. On at 8pm a caregiver reported to the nurse that resident#1 was missing. Law enforcement was called. Resident was located within 30 minutes a couple of miles away from the facility. No injuries were found. In an interview on at 11:30am with resident#1's family member, he stated it was a temporary situation at the facility for the resident. The plan was always for him to stay there less than a month and then move him to Michigan which is where he is now. He stated he never had any issues with the care and services that the facility provided. He stated his father was restless and wanted to move out and he decided to just leave. He stated, "the staff there keeps a very good on the residents however my father just decided to leave when they were not looking." In an interview on at 12:30pm with caregiver E stated she was the receptionist at the time of the incident. She stated she left to move her car and, on the way, she saw him in the parking lot. She stated he asked how to get to St	A 025		

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A 025	Continued From page 3 Pedro church. He knew what to ask for and where it was. She stated he was a little but eventually went inside with her. She stated the receptionist, who let him out of memory care and through the front door, was there at the time of the incident. She stated the receptionist was thrown off and thought the resident was a family member. She stated the facility does elopement drills and has done them usually once a month. She stated she has done it at least 3 times this year. She stated she did not know he was an elopement risk. 2. In a record review of resident#2 confirmed an admission date of [redacted] and a health assessment dated [redacted]. The resident's health assessment confirmed a medical history of [redacted], assistance with medication, wears an [redacted] patch, and assistance with daily living to include [redacted], self-care, toileting and bathing. The resident resided in the memory care unit and was an elopement risk. In review of resident#2's daily observation notes revealed the following: On [redacted] the resident was brought [redacted] to the facility by law enforcement. He was observed across the street in another business parking lot. The community team went to identify the resident across the street while the caregivers in the facility looked for residents in house to be sure. The resident was last seen in the dining area prior to hourly check. Resident stated he climbed the ladder outside in the courtyard and got over the fence. the lawn service persons were in and out of the courtyard at that time and might have left their ladder outside in the courtyard. The residents did not incur any injuries.	A 025		

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A 025	Continued From page 4 In an interview on ..... at 11:00 am with caregiver B stated all the staff does elopement drills every month. She stated the policy is to check on the residents hourly and if one is missing, we alert the nurses and the administrator, and they will call 911. She stated the doors to memory care can be opened if you lean on them for 15 seconds and sometimes the alarm will sound and sometimes it will not. She stated he probably leaned on the door that goes out to the courtyard for 15 seconds and no one realized he was out there. She stated she was not aware he was an elopement risk. She stated we always need more staff to handle the residents as they need a lot of assistance In an interview on ..... at 11:30 am with caregiver C stated that resident#2 has a 24-hour sitter now after the incident. She stated he can be aggressive, and he always wants to leave the facility. She stated the facility does elopement drills monthly. She stated the residents are checked every 2 hours. She stated no one noticed that resident#2 was in the courtyard. She stated no one noticed him climbing over the fence, even though you can see that area from the large window in the common area. She stated she was not aware he was an elopement risk. In an interview on ..... at 12pm with resident#2, stated he does not want to be here and wants to go home. He stated he climbed over the wall fence in the courtyard and got out and apparently no one saw him as he was able to get to the other side. He stated it is a prison here and he does not belong here. He stated he is calling his attorney to straighten this out so he can leave. He stated he got stuck here at the facility but when he left the police brought him ..... here. He stated he is not happy here and wants to go	A 025		

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A 025	Continued From page 5 home. In an interview on [redacted] at 12pm with caregiver D, stated the exit doors at the facility in the memory care are faulty and can be opened after 15 seconds. She stated the staff checks on the residents every 2 hours but if we are busy in between that time the residents that still have some [redacted] memory can remember that and open the doors. She stated she does not believe resident#2 climbed over any wall but left through the courtyard gates when the lawn people were here. She stated she did not know the resident was an elopement risk. She stated there are never enough staff with the population they have in the memory care unit. In review of the facility's elopement policy is defined as a resident gaining unauthorized access to exterior of community and secured courtyard. In review of law enforcement's report for resident#2 it states on [redacted], at 1323 hours I was dispatched to 1056 Willa Springs Dr., Winter Springs, Seminole County, Florida in reference to a well-being check. Upon arrival, I made contact with the business staff and an elderly male. The male was identified as resident#2. I asked the resident where he was going, and he stated he was trying to get [redacted] to Cedar Bay where he has his vehicle. I asked the resident if he had any family in the area and he stated no. I asked the resident how he got to the business and he stated he walked. I asked him where and he stated from across the street. The facility across the street is Arden Court memory care community. I made contact with the facility, and they verified he was a resident there. The facility was not aware he had left the facility. I	A 025		

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A 025	Continued From page 6 walked the resident to the facility and brought him where he was checked out by the fire department and cleared. The Department of Children and Families were contacted as the facility did not know he was missing. In an interview on at 11 am with the department of children and families, they stated they were at the facility to check on the elopement of resident#1 today. He stated he was not aware of the elopement of resident #1 and would investigate the incident. In an observation on of the facility's courtyard, it revealed a locked exterior door to get to the courtyard and a 7- fence around the courtyard with a locked gate. The courtyard leads to the facility's front parking lot by the main road. There is a large picture window in the common area that enables the caregivers to see the courtyard from the inside of the facility. Observation of resident#1 revealed he was wearing an identification bracelet with the name of resident and facility; facility address and phone number. In an interview on at 1pm with the director of nursing, she confirmed all the above findings and stated the resident#1 and 2 were here on respite and it did not give the facility a chance to know them. She stated the receptionist who let resident #1 out of the memory care and out of the front door was put on leave. She stated she is not sure how resident#2 was able to get in the courtyard and climb the fence without caregivers and the nurse not seeing him. Photographic evidence obtained Class II	A 025		

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