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
	AL11965368	A. BUILDING: _____ B. WING _____	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AT OCOEE	80 NORTH CLARK RD OCOEE, FL 34761

(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
CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	CZ821		

AHCA Form 3020-0001

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

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CZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	CZ821		

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CZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	CZ821		

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CZ821	Continued From page 3 to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to electronically submit to the Agency for Health Care Administration (AHCA,) a preliminary report within 1 business day and a full report within 15 days of learning 1 of 1 sampled resident had a positive test for after being sent to the hospital (#8.) Findings: A review of resident #8's record revealed a facility admission date of . The resident's medical history included . The resident needed assistance with self-administration of medications. On at 10:44 am nurse G documented the resident was in bed and unresponsive to all stimuli. 911 was called and the resident was transported to a hospital. A hospital history and physical indicated the resident was sent to the hospital secondary to being unresponsive at the facility. A hospital drug screen was positive for .	CZ821		

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CZ821	Continued From page 4 On . . . . at 4:02 pm the resident returned to the facility. A and drug screenings collected at the facility were both negative. On . . . . at 4:04 pm, the resident's family member said he was told by hospital staff that the resident's change in condition was caused by , . The family member said the facility's administrator said an investigation found no , in the facility. The family member said a facility doctor believed the result of the . . was a false positive. On at 2:15 pm, the administrator said an investigation was conducted in response to the drug screening results by way of conducting a medication cart audit which found no . . . , on site. On at 3:06 pm, the DON said she learned of the positive . . . , result from the resident's family member after the resident's return to the facility. On at 12:33 pm, the DON said she checked every medication cart and verified there was no . . . . , in the facility. She said someone in corporate told her to wait for the results of the drug screenings to return and since they were negative AHCA did not have to be notified. On at 3:06 pm, nurse G said the resident was not completely unresponsive on . . . but rather, she was alert and not verbally responsive. The nurse said neither this resident nor any other residents were prescribed , . Unclassified	CZ821		

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A 000	Initial Comments 2024007051 & 2024007930 A complaint investigation (#2024007051 & #2024007930) and a generator monitoring was conducted at Madison at Ocoee on & . The facility had deficiencies at the time of the survey.	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	A 025		

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A 025	Continued From page 6	A 025		

supervision as appropriate for each resident, including the following:
(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 observations, record reviews and interviews, the facility failed to provide adequate supervision when 1 of 2 sampled residents eloped from the facility (#9).

Findings:

A review of resident #9's record revealed a facility admission date of . The resident's medical history included , and . A health assessment form (1823) indicated

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A 025	Continued From page 7 the resident was not an elopement risk. On . . . . . at 4:10 pm the resident was noted with increased as evidenced by signing out of the facility, taking a walk outside and not remembering the directions to get to the facility. She was escorted . . . by law enforcement. The resident said she remembered the name of the facility but not the directions to get . The resident was encouraged not to leave the facility alone. On . . . . at approximately 3:15 pm the resident's spouse reported to staff that the resident went for a walk around 2:30 pm and had not returned. The resident did not sign out at the front desk and no staff witnessed her leaving. Staff searched the building and the parking lot but did not locate the resident. At approximately 4 pm the resident was returned to the facility by law enforcement. The resident said she was trying to walk to a drug store but got lost and ended up at a craft store located approximately one mile from the facility. The resident was educated to sign out and inform staff before leaving. Frequent checks were implemented due to the resident being an elopement risk. On . . . . . at 1:50 pm, the resident said "I always have gotten lost. I got nervous." She believed staff drove by her on . . . . and gave her a ride to the facility. She said the facility staff spoke to her about signing out. She could not recall if she'd gone out since the incident. She believed she was going to a drug store both times she left. She said she was new to the area having moved here from another state. She said she did not sustain injuries either time. She did not recall law enforcement bringing her . When asked if she had identification with the	A 025		

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A 025	Continued From page 8 facility's information, she removed her driver's license and a facility business card from her purse. She said she takes the purse when she leaves the facility. On at 1:58 pm, the resident's spouse said the resident gets turned around. The spouse said the resident no longer took walks since the incident. The facility's elopement policy did not define elopement. On at 2:15 pm, the administrator said elopement was defined as when a resident did not sign in and out. The administrator said the resident got lost on because she was new to the area. The administrator did not know if facility staff called law enforcement on . She believed police drove by the resident then stopped and brought her . The administrator said the front desk concierge was responsible for checking to see if residents signed out. The administrator said she did not interview concierge F after the incident then said it was the business office manager's (BOM) responsibility to do that. The administrator did not know if the BOM conducted an interview. The administrator said residents sometimes followed visitors out the front door. The facility's front doors are locked and a button on the wall behind the front desk has to be pushed to open them. On at 2:53 pm, the DON said the solution to prevent the resident from leaving alone was to encourage her not to go out alone. The DON said there was only one day since when the resident went out with her spouse.	A 025		

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A 025	Continued From page 9 On at 3:30 pm, caregiver D said that when the resident first moved in, she approached the front desk often and said she was leaving. Staff redirected the resident to her room. The caregiver did not recall the resident leaving on and did not recall the last time she saw the resident before she went out on . On at 3:40 pm, caregiver B said she saw the resident in the dining room after dinner on . The resident told the caregiver she was looking for her mom and that she received a call from her mom. The caregiver said she and nurse G went in the caregiver's car to look for the resident. They located the resident on the road located in front of the facility, walking on the sidewalk on the opposite side of the road. The caregiver said the resident was . The resident did at that time and still constantly says she wants to go out for a walk. On the caregiver saw the resident in her room with her spouse at 2 pm. The caregiver did not know the resident left and learned about it when the spouse asked if anyone saw her. The caregiver said police returned the resident on . On at 9:16 am, concierge F said she did not let the resident out on and did not know the resident left. The concierge said maybe the resident was let out by the staff who relieved her during her lunch break, or another resident let her out. The concierge said when residents come to the front desk and say they're going out she makes sure they sign out. The concierge said she did not know before the elopement that the resident got lost during her outing. The concierge said the resident was now not allowed to leave by herself. The concierge said that since the resident had approached	A 025		

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A 025	Continued From page 10 the desk to be let out and the concierge redirected her to speak with a nurse or the administrator. On . . . . . at 9:40 am, the resident was seen walking around the first-floor common area near the front desk. She did not have her purse. On . . . . . at 10:15 am, nurse E said that when the resident left the facility on it was not considered an elopement because she signed out. The nurse said the resident forgot how to get . . . because she was new to the area. The nurse said the facility learned about the resident's inability to find her way . . . when the police brought her . The nurse did not know what caregiver B was talking about when she said she picked the resident up in her car. The nurse said that on . . . . the resident's spouse alerted staff when the resident did not return. The nurse said she did not know, nor did she question how the resident left the facility. The nurse said maybe the resident had a key fob to open the front doors, but she was not sure. The nurse said she told the resident about outing activities and nursing conducted frequent checks on her. The nurse said she also told the resident she can go to the enclosed patio. The nurse said since the incident the resident had not approached her about leaving. On at 11:30 am, resident #12 was seen pushing the button to let someone inside the facility. No staff was at the front desk. On at 12:23 pm, the administrator said the resident was not issued a key fob. On at 12:40 pm, activities staff H, who relieved concierge F for her break on ,	A 025		

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A 025	Continued From page 11 said she did not see the resident leave and did not know the resident was gone until the resident's spouse asked about her. Staff H said the concierge is supposed to make sure residents sign in and out. Staff H said the resident still goes to the front door then goes to the front desk and asks to be let out. Staff H said other times the resident comes to the desk first and asks to be let out. Staff H said the resident is not allowed to leave alone and has to be redirected. On at 3:06 pm, nurse G said it was on that she and caregiver B picked the resident up in the caregiver's car. The nurse said it was between pm when the resident said she was going outside to speak with her mom because she could not get reception on her phone. The nurse said she watched the resident walk towards the sidewalk in front of the facility. About 30 minutes later when the resident did not return, the nurse and caregiver B took the caregiver's car and picked the resident up. The nurse said the resident was near a church on the opposite side of the road that ran in front of the facility. The resident was walking in the direction of the facility. The nurse said the resident said she was making her way to the facility. The nurse said the resident does try to go out the front doors, but the concierge was there to stop her. The incident was not documented in the resident's record. Class II	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS.	A 032		

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A 032	Continued From page 12 (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. (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	A 032		

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A 032	Continued From page 13 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 observation, record reviews and interviews, the facility failed to make a daily effort to ensure 1 of 2 sampled residents who was identified as being at risk for elopement had identification (ID) on their person that included their name and the facility's name, address, and telephone number. (#4) Findings: On at 9:44 am, observations of Resident #4 sitting on the sofa in the memory care unit of the facility did not reveal the resident was wearing an ID bracelet. A review of the incident report dated outcome revealed resident elopement, if the elopement places the resident at risk of harm or injury. At approximately 6:30pm Resident #4 was	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965368	A. BUILDING: _____ B. WING _____	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 032	Continued From page 14 observed by a staff member sitting in front of the bar next to the community. Resident #4 did not sign out at the front desk or notify any of the staff that he was leaving. A review of the facility's updated Elopement/Missing Resident Drills/Missing Resident policy does not state any resident identified as being at risk for elopement will have identification (ID) on their person that included their name and the facility's name, address, and telephone number. On at 10:20 am, Resident #4 stated, he does not recall leaving the facility going next door to the restaurant. The resident stated he does not have an ID , the facility has not put one on him, and no one checks daily or reminds him. A record review of Resident #4 revealed an admission date on . A 1823 Health Assessment Form indicated a medical history of 's, Aneurysm, Hypoxemia, , Memory Loss, and was identified as an elopement risk. A review of the Resident Sign Out Log dated revealed Resident #4 signed out at 12:00pm and returned at 4:15pm to the facility. A review of Resident #4's facility's note dated at 16:37 read, "went with wife." A review of Resident #4's Medication Observation Records from - , did not reveal the facility placed an ID bracelet on the resident or made a daily effort to ensure resident had ID on their persons.	A 032		

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
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A 032	Continued From page 15 The Administrator was asked if daily checks were made or if Resident #4 has on an ID bracelet. On at 2:35 pm the Administrator stated "no, not that I know of. No, he does not have an ID . Maybe that's something we need to put in place. No one in Memory Care has on a ." On at 10:30 am Staff E stated, "I don't think they're required to have an ID . No one in memory care has a ." Class III	A 032		