

Agency for Health Care Administration

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                          |  |                                                                    |
|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968826</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/27/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AURORA GARDEN CARE, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6716 CONGRESS ST</b><br><b>NEW PORT RICHEY, FL 34653</b>                     |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {A 000}                                                            | Initial Comments<br><br>A revisit to the biennial survey of _____ was<br>conducted at Aurora Garden Care on _____.<br>The facility had deficiencies at the time of survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | {A 000}                                                                        |                                                                                                                          |  |                                                                    |
| {A 032}<br>SS=D                                                    | 59A-36.007(7) FAC Resident Care - Elopement<br>Standards<br><br>59A-36.007<br>(7) ELOPEMENT STANDARDS.<br>(a) Residents Assessed at Risk for Elopement.<br>All residents assessed at risk for elopement or<br>with any history of elopement must be identified<br>so staff can be alerted to their needs for support<br>and supervision. All residents must be assessed<br>for risk of elopement by a health care provider or<br>a mental health care provider within 30 calendar<br>days of being admitted to a facility. If the resident<br>has had a health assessment performed prior to<br>admission pursuant to paragraph 59A-36.006(2)<br>(a), F.A.C., this requirement is satisfied. A<br>resident placed in a facility on a temporary<br>emergency basis by the Department of Children<br>and Families pursuant to Section 415.105 or<br>415.1051, F.S., is exempt from this requirement<br>for up to 30 days.<br>1. As part of its resident elopement response<br>policies and procedures, the facility must make,<br>at a minimum, a daily effort to determine that at<br>risk residents have identification on their persons<br>that includes their name and the facility's name,<br>address, and telephone number. Staff trained<br>pursuant to paragraph 59A-36.011(10)(a) or (c),<br>F.A.C., must be generally aware of the location of<br>all residents assessed at high risk for elopement<br>at all times.<br>2. The facility must have a photo identification of<br>at risk residents on file that is accessible to all<br>facility staff and law enforcement as necessary.<br>The facility's file must contain the resident's photo | {A 032}                                                                        |                                                                                                                          |  |                                                                    |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Agency for Health Care Administration

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                      |                                                                                                                          |  |                                                                    |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968826</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/27/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AURORA GARDEN CARE, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6716 CONGRESS ST</b><br><b>NEW PORT RICHEY, FL 34653</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {A 032}                                                            | <p>Continued From page 1</p> <p>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.</p> <p>(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:</p> <ol style="list-style-type: none"> <li>1. An immediate search of the facility and premises,</li> <li>2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,</li> <li>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,</li> <li>4. The continued care of all residents within the facility in the event of an elopement.</li> </ol> <p>(c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all staff had participated in at least 2 elopement drills on an annual basis.</p> <p>Findings included:</p> <p>A record review was conducted on _____ of the only two elopement drills provided by the facility (photographic evidence obtained). The two elopement drills did not contain a staff roster</p> | {A 032}                                                                                              |                                                                                                                          |  |                                                                    |

Agency for Health Care Administration

|                                                                    |                                                                                                                                                                                                                                                                                                |                                                                                                      |                                                                                                                          |  |                                                                    |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968826</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>01/27/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AURORA GARDEN CARE, LLC</b> |                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6716 CONGRESS ST</b><br><b>NEW PORT RICHEY, FL 34653</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {A 032}                                                            | <p>Continued From page 2</p> <p>of who attended the elopement drills on each occasion.</p> <p>A interview was conducted on _____ at 9:50a.m. with the Manager who agreed they were unable to provide a staff roster of who had attended each of the two elopement drills.</p> <p>Class III</p> | {A 032}                                                                                              |                                                                                                                          |  |                                                                    |