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
	AL11968706	A. BUILDING: _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT AVALON PARK	13798 CYGNUS DR ORLANDO, FL 32828

(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 re-licensure survey with Extended Congregate Care (ECC) and a generator monitoring was conducted at Encore at Avalon Park 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 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 facility's documentation, resident record review and interview, the facility failed to provide appropriate supervision for 1 of 5 sampled residents (#15) as required to prevent elopement from a secured Memory unit; and {2} the facility failed to follow a medication order as prescribed by a healthcare provider for 1 of 5 sampled residents (#2). Findings: 1. An incident was reported on at 7 PM, that Resident #15 eloped outside of the secured Memory Care unit, and found in the	A 025		

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A 025	Continued From page 2 stairwell on the 3rd floor near the exit door leading to the roof by Caregiver I on her and with a coming from her and Nurse G assessed her and called 911 to send her out to the hospital. Resident #15's record review revealed admission date . The last 1823 Health Assessment dated identified Resident #15 an elopement risk. Her medical history listed were and her status & . She needs assistance with activities of daily living (ADLs), eating, grooming, transferring with high risk for . Supervision with ambulation, bathing, and toileting. She needs assistance with self-administration of medications. A facility note dated at 1:05 AM by Nurse G documented late entry for at 9 PM. Notified that Resident #15 eloped at 7:39 PM. All staff proceeded with searching for Resident #15. Resident #15 was found at 8:08 PM on the roof of the building and notified that Resident #15 was lying on the ground from an apparent . 911 called immediately. All caregiver staff assisted Resident #15 to a wheelchair and down the stairs. Nurse G assessed Resident #15 and observed a large amount of to middle of Resident #15 forehead and right side of her . An ambulance arrived and transported Resident #15 to the hospital. There was no facility documentation that Resident #15's physician and family were notified for this incident. A facility note dated at 3:13 PM by Administrator documented Correction from	A 025		

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A 025	Continued From page 3	A 025		

previous note, Resident #15 did not leave the premises as she does throughout the facility and staff could not find her, but she was still on campus. Therefore, it was not an elopement.

A facility note dated at 11:19 AM by Nurse K documented Resident #15 returned to the facility from the hospital via medical transport. Vitals good. Resident #15 was awake and responsive. Observed healing scar on left forehead, on the . Skin dry and intact.

There was no facility documentation that Resident #15's physician and family were notified.

A facility note dated at 8:03 PM by Nurse H documented Resident #15 complained of . As needed 500 milligram (mg) given. Resident #15 was . Temperature 97.5 degrees and . Observed Resident #15 slow in pace today but continued to ambulate throughout the unit. Resident #15 had good meal intake and fluids. Assisted Resident #15 with toileting and hygiene care. Niece visited with snacks and later brought to the facility washcloths, towels and pullups.

A facility note dated at 3:32 PM by Nurse L documented Resident #15 presenting exit seeking behaviors and needed redirection & reminders to use her walker. High risk.

A review of the hospital records documented on at 8:46 PM, Resident #15 arrived at the emergency room and later admitted for two (2) more days in the hospital for escaping the Memory Care and found down on the roof of the facility, after what appeared a ground level . In

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A 025	Continued From page 4 addition, Resident #15 had a large right-side jaw ⌄ to the and a left frontal hematoma on her forehead. There was no documented evidence that the facility followed their own elopement policies & procedures that stated below: The state of Florida regulations require that an Assisted Living Facility develop and implement the elopement policy. The purpose is to which to prevent elopement from occurring and responding to the elopement when it occurs. An elopement is defined as when staff determines a resident is missing or whenever a resident leaves the secured confines of Memory Care unattended by staff or family. Purpose: 1. to assess and identify at risk residents for elopement, prior to admission and at admission. Reassessed regularly after admission to prevent elopement. 2. to develop and implement an effective method to locate a missing resident in a timely & efficient manner. On at 4:02 PM, an interview with the Director of Nursing (DON) stated that Resident #15 was not found on the roof outside, she was found in the stairwell on 3rd floor because the magnetic lock for the exit door to 1st floor stairwell was not locked. On at 4:41 PM, an interview with Caregiver I stated that she was assisting	A 025		

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A 025	Continued From page 5 residents for bedtime and when she arrived at Resident #15's room, she was not in her room. She looked for her all through the Memory Care unit but could not find her. Caregiver I called on the radio to all staff working that Resident #15 was missing. After about 20 minutes of searching for Resident #15, Caregiver, I found Resident #15 in the stairwell on the 3rd floor near the exit door leading out to the roof on her and , from her . On at 4:59 PM, an interview with Nurse H stated that she called the family to inform them of the incident and Nurse G assessed Resident #15 and called 911 after she was found. On at 5:10 PM, an attempted telephone interview with Nurse G, there was no answer and left a voicemail message. On at 5:52 PM, an interview with the Maintenance Technician confirmed that there was an issue with the magnetic lock on the 1st floor exit door to the stairwell. He stated that the magnetic lock was broken. Furthermore, he stated that the last time he checked on the door was locking and when he returned to work on he found it not locking. On at 5:55 PM, an interview with the Administrator did not agree about Resident #15 eloped and found on the 3rd floor stairwell because she was still inside the building. The Administrator provided an all-exit door check off list by staff that began on (thirteen days after Resident #15 eloped and found) and not immediately after it was discovered broken on	A 025		

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A 025	Continued From page 6 (Photographic Evidence Obtained) Surveyor: Williams, Robin 2. Review of resident #2's health assessment form (1823) revealed the resident needed assistance with self-administration of medications. However, the resident's medications were administered through his tube (.) On a health care provider wrote an order to check the resident's prior to giving , and to give , ER 80 milligrams (mg) if , ( ) was greater than 150. Review of the resident's medication observation record (MOR) revealed the was given without readings on , , and . The only reading when the was given on was and on was , both of which reading was too low to give the medication. On at 2 pm, the finding was discussed with the director of nursing. On at 4 pm, the DON said she was unable to provide additional readings. On at 4:17 pm, both nurse J (gave the medication on) and nurse K (gave it on and) said they did check the resident's before giving the . On at 4:40 pm, both nurse J and nurse K	A 025		

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A 025	Continued From page 7 said they looked but could not find the , readings they took. Class II	A 025		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.	A 054		

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A 054	Continued From page 8 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the medication observation record (MOR) for 1 of 5 sampled residents (#2) accurately reflected the staff who offered or administered the resident's medications. Findings: Review of resident #2's health assessment form (1823) revealed the resident needed assistance with self-administration of medications. However, the resident's medications were administered through his tube (.) Review of the resident's MOR revealed unlicensed caregiver A signed that she administered the resident's medications through his on at 8 am and 6 pm and his nutritional liquid supplement through the tube at 12 pm. Unlicensed caregiver D signed that she administered the resident's medications on at 5 am and 6 am and his liquid supplement at 6 am. On at 12:50 pm, unlicensed caregiver A said that although she signed the MOR on , she poured the medications and handed the cup to nurse M, who then administered them. The caregiver said that was the way she did it every time with this resident. On at 1:04 pm, a voice message was left for nurse M, but she did not return the call. On at 1:15 pm, caregiver D said she did not give resident #2 medications. She said the nurse signed the electronic MOR under caregiver	A 054		

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A 054	Continued From page 9 D's username. On at 2 pm, the findings were discussed with the DON, who said she did not know caregiver A poured the medications for the nurse to administer. The DON also believed the nurse signed the MOR under caregiver D's username. Class III	A 054		
A 057 SS=D	59A-36.008(8) FAC Medication - Over The Counter (OTC) Products (8) OVER THE COUNTER (OTC) PRODUCTS. For purposes of this subsection, the term over the counter includes, but is not limited to, over the counter medications, , nutritional supplements and nutraceuticals, hereafter referred to as OTC products, that can be sold without a prescription. (a) A facility may keep a stock supply of OTC products for multiple resident use. When providing any OTC product that is kept by the facility as a stock supply to a resident, the staff member providing the medication must record the name and amount of the OTC product provided in the resident's medication observation record. All OTC products kept as a stock supply must be stored in a locked container or secure room in a central location within the facility and must be labeled with the medication's name, the date of purchase, and with a notice that the medication is part of the facility's stock supply. (b) OTC products, including those prescribed by a health care provider but excluding those kept as a stock supply by the facility, must be labeled with the resident's name and the manufacturer's label with directions for use, or the health care provider's directions for use. No other labeling	A 057		

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A 057	Continued From page 10 requirements are required. (c) Residents or their representatives may purchase OTC products from an establishment of their choice. (d) A health care provider's order is required when a nurse provides assistance with self-administration or administration of OTC products. When an order for an OTC product exists, the order must meet the requirements of paragraphs (b) and (c) of this subsection. A health care provider's order for OTC products is not required when a resident self-administers his or her medications, or when unlicensed staff provides assistance with self-administration of medications. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the correct labeling was on 2 of the 3 over the counter (OTC) medication for sampled resident (#12). Findings: In a review of resident#12's medication order record (MORs), it revealed the following OTC medications and orders: Bayer , 81 mg, take 1 tablet by once daily, and , 500mg, take 2 tablets by twice daily. In a review of the manufacturer's label on the bottle for Bayer , , it stated take 1 , every 4 hours for 8 hours. In a review of the manufacturer's label on the bottle for , , it stated take 2 tablets every 6 hours. In an interview on at 12:30pm, with the director of nursing, she stated she was not aware	A 057		

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A 057	Continued From page 11 if the manufacturer's label differs from the physician order that a label must be placed on the OTC bottle with the name of the resident and physician orders. Photographic evidence was obtained Class III	A 057		