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
	AL11911313	A. BUILDING: _____ B. WING _____	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALABAMA OAKS OF WINTER PARK	1759 ALABAMA DRIVE WINTER PARK, FL 32789

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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 review and interview, the facility failed to report to the Agency for Health Care Administration a 1- Day and 15- Day Adverse Incident Report in a timely manner pursuant to Statute 58A-5. 0242, Florida Administrative Code. Findings: In a review of the facility's observation notes it revealed the following: Resident left out of gate of the facility between 1:50 and 2:30pm. Resident was brought by fire department Report states the activities aid saw the resident laying down in his room and the resident then stated he went for a walk to get his and when he got 2 miles away from facility then got tired and laid down on the ground and then was approached by paramedics. He produced his identification that had the address and phone number of the facility and his ID card which has the same information. Resident was last seen at the gate around 1:30pm on . The resident was with the case manager between 1:10pm and 1:30pm, at the facility, who was there to check up on the status of his .	CZ821		

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CZ821	Continued From page 4 When the case manager was leaving the resident walked her to the front gate and was instructed to walk inside the facility. The case manager stated she closed the gate behind her. Timeline of elopement was between 1:40pm and 2pm. Resident was returned to the facility between 2:20pm and 2:40pm. He was off the property 40 to 50 minutes. In a review of the 1-day and 15-day adverse incident report sent by the facility to the agency, the elopement incident occurred on . The 1-day report was not sent to the agency until and the 15-day report was not sent to the agency until . In an interview on at 12pm with the administrator, she confirmed the findings. Unclassified	CZ821		
A 000	Initial Comments A complaint (#2025001180) and a generator monitoring was completed on at Alabama Oaks of Winter Park. Deficiencies were 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	A 025		

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A 025	Continued From page 5 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 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.	A 025		

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A 025	Continued From page 6 (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 provide supervision to prevent an elopement for a resident he was assessed to be at risk for elopement for 1 of 2 sampled residents (#1). Findings: Incident report dated , Resident#1 with history with memory disturbances, , paranoia and . On the resident had a visit from his case manager at 1:30pm, who came to see about his . The resident had requested an to have his checked. The case manager left the facility at 1:45pm and the resident walked her to the front gate. The case manager informed the resident to turn and go inside the facility. The case manager then got in her car and left the facility. Staff A states she saw the resident away from the front gate and go to the facility. At around 2:20pm the resident was returned to the facility by law enforcement. The resident stated to staff B he was on his way to the store to have his checked and then sat down on the sidewalk, which was 2 miles from the facility, because he was tired. The resident was brought to the facility by paramedics and brought to the facility.	A 025		

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A 025	Continued From page 7 In a review of resident#1's health assessment dated , it confirmed a medical history of , , , MCI with memory disturbance, paranoia, , , is unaware of limitations, risk and an elopement risk. The resident required assistance with medication administration and no assistance with daily living skills. In a review of the facility's observation notes it revealed the following: Resident keeps pacing until mid-night. Woke up at 3:30am to pace, then went to bed. The gate was discovered by staff to be broken and then thought the gate was fixed. Resident was during the night looking for airplanes. Resident left out of gate between 1:50 and 2:30pm. Resident was brought by fire department Report states the activities aid saw the resident laying down in his room and the resident then stated he went for a walk to get his and when he got 2 miles away from facility then got tired and laid down on the ground and then was approached by paramedics. He produced his identification that had the address and phone number of the facility and his ID card which has the same information. Resident was last seen at the gate around 1:30pm on . The resident was with the case manager between 1:10pm and 1:30pm, at the facility, who was there to check up on the status of his . When the case manager was leaving the resident walked her to the front gate and was instructed to walk inside the facility. The case manager stated she closed the gate behind her. Timeline of elopement was between 1:40pm and 2pm. Resident was returned to the facility between	A 025		

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A 025	Continued From page 8 2:20pm and 2:40pm. He was off the property 40 to 50 minutes. In a review of Law enforcement report dated : Dispatched to medical call that turned out to be simply public assistance. One elderly resident was given a ride a short distance up the road to his residence. He denied any medical complaints. In a review of the facility's elopement policy revealed an elopement occurs when a resident has left the property and did not inform staff of where he or she was going, and 8 hours has passed without seeing the resident. Unless the resident has been identified by management as a high risk, then it would be if no one saw the resident in 3 hours. Observation was made on at 11am of the front gate, the gate was locked and secured and operable. Observed resident#1 around the facility in the hallways with identification on him. Observed resident#2 with identification on . In an interview and observation of resident#1 on at 9:45am Resident #1, was around the cottage and stated he could not remember where his room was located. He did not understand most of the questions he had asked him. He stated he could not remember the incident and that he is allowed to walk out of the front gate whenever he wants to. He stated he always carries his wallet on him which has an identification with this address on it. He stated sometimes he forgets things. He stated he likes living here but he needs to leave to do things from time to time. He stated he likes the staff and	A 025		

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A 025	Continued From page 9 the other residents. He gets his medications daily. In an interview on at 10:00am with staff C, she is a caregiver and has worked at this facility for 12 years. She stated resident#1 can be exit seeking as he believes he can leave whenever he wants to. She stated she was not working at the time of the occurrence. She stated when visitors come, they sometimes slam the gate and that causes the gate lock to break. She stated they have fixed the gate since resident#1 eloped. She stated she is not aware of any other elopements at the facility. She stated they do elopement drills 2 x per year. She stated resident #1 had attempted elopement in the past about a year or more but did not remember the details of when or how. In an interview on at 10:15am with staff D she stated she is a med tech and has worked at the facility for 14 years. She stated the visitors when they leave keep slamming the gate to close it. She stated that is why we put a sign up to gently close the gate and make sure it is secure. She stated she was not working the day the elopement occurred. She stated resident#1 gets along with staff and other residents and is not a behavioral problem. She stated resident #1 had attempted elopement in the past but did know all the details of when or how. In an interview on at 10:30am Staff E stated she has been working here for 5 months and only works 2 x per week. She stated she is not aware of the elopement and does not know what an elopement drill is. She stated there are 3 caregivers in cottage one and 3 caregivers in this cottage there is usually one caregiver, but the other caregiver/floater comes to assist.	A 025		

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A 025	Continued From page 10 In an interview on at 12pm with the administrator, she stated the gate lock was , and the pen and would open with any code you put in. She stated the owner replaced the lock the same day and we have not had any issues since then. She stated there was an in-service for elopement procedures and policies and an elopement drill completed on with all staff. In an interview on at 1pm with the power of attorney, he stated that resident#1 had another elopement a few years ago at the facility where he climbed over the fence. He stated the facility never informed him of this recent elopement nor did the case manager. He stated his father gets and is exit seeking at times. He stated he did not remember the details of the previous elopement. He stated he assumed the facility staff supervised resident #1 constantly as he is an elopement risk. In an interview on at 1pm with staff A, the case manager came to assist with his and when she got done the resident followed the case manager to the gate. She stated she was assisting another resident inside the facility. She stated she did not see him leave, she said no one did. She stated it was mentioned to her before that he attempted to elope before. She stated she checks on the residents every hour; she stated that it is the policy. She stated the gate might have been faulty as the handle was loose and no one noticed that before. She stated there was a lot of traffic happening on the day of the incident. She stated a lot of people coming and going through the gate that day. She stated she feels there is enough staffing for the number of residents.	A 025		

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A 025	Continued From page 11 In an interview on at 1:30 pm with the case manager of Resident#1, she stated the resident followed her to the front gate of the facility and she told him to turn . She stated she closed the gate behind her and heard it lock. She stated she did not see the resident leave the premises. She stated she informed the family by email after the incident and apparently, they did not get the message. Photographic evidence obtained Class II	A 025		