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
	AL11970040	A. BUILDING: _____ B. WING _____	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY POINTE AT UCF	2120 HESTIA LP OVIEDO, FL 32765

(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 (#2025004526) and a generator monitoring were conducted on at Legacy Pointe at UCF. 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		

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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 observation, record reviews and interviews, the facility failed to provide appropriate supervision to prevent elopement for 2 of 3 sampled residents (#3 & #4) and failed to ensure appropriate care and services were implemented to prevent a with injury (#3). Findings: 1. In a review of resident#3's record it revealed an admission date of and a health assessment dated . Medical history confirmed with , , history of , nodule, left ankle and , , decline,	A 025		

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A 025	Continued From page 2 ambulatory without devices, special precautions with , assistance with medication, assistance with daily living to include ambulation, , eating, self-care, bathing and toileting. The resident was designated as an elopement risk. Resident resides in the memory care unit. Review of the incident reported , revealed at approximately 8:45 am on resident #3 became upset and agitated during breakfast. The resident punched at a staff person and then began walking quickly down the hallway of the memory care unit and banging on other residents' doors. Staff attempted to redirect her and get her to slow down. At approximately 9:00 am the nurse went to resident #3's room to assist with medication and noticed the resident was not in her room. Staff began a search and found an empty room with the window open. The resident was found walking on the sidewalk outside the facility near the guard gate, approximately 100 from the facility. Staff walked the resident towards the facility and the resident began jogging and tripped. The resident sustained a to her left , area. Emergency medical services were called, and the resident was sent to the hospital. The resident was treated and sent to the facility on the same day. During an interview on at 10:35am with staff D, she stated the first week the resident #3 was here we were trying to get her to eat but her was angry. The resident was fighting everyone, swinging at everyone and would run down the hall. She stated on the day of the elopement, resident #3 went into an empty room, she doesn't remember the room number and she was able to open the window as the tabs were opened to the window. The resident was able to climb out the window into an open field. The open	A 025		

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A 025	Continued From page 3 field was in the front where everyone parks. She stated when I discovered the window was open, we went outside and went towards the independent living where she originally came from and then all around the building. She stated she was found by the guard gate in front of the facility. I brought her inside to the memory care unit. She stated when the resident ran into the building she tripped and . was called as result and called the ambulance. Staff D stated resident #3 only got a scrape on her nothing broken. 2. Review of resident #4's record revealed an admission date of and a health assessment dated . Medical history confirmed , ambulatory, alert and oriented x 2 with and paranoia, assistance with medication, assistance with daily living to include bathing. The resident was designated as an elopement risk. The resident resides in the memory care unit. Review of the incident report dated , revealed at approximately 3:48 pm while staff were doing rounds, resident #4 was observed through a window walking outside the memory care unit, on the community grounds. The resident was brought to the facility by staff. It was discovered that the resident had the locking tabs on the window, lifted the window, popped out the screen and climbed out. The resident later stated she just wanted fresh air. All windows in the memory care unit have now been secured. In a review of the facility's elopement policy it states, any resident assessed to have , decision-making ability for their own safety needs, and the ability and intent to leave the facility will	A 025		

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A 025	Continued From page 4 be identified at admission and appropriate interventions will be implemented to reduce the risk of elopement. If elopement risk is identified interventions will be developed immediately. There was no documentation given for the facility's policy. During observation on at 11:15am, resident #3 and resident #4 were sitting in the common area participating in activities. They had identification on their person. Observation of the memory care windows showed locks now in place on the windows. Windows only open 3 inches from the sill. During an interview on at 11:03 am with the wellness director, she stated that all memory care residents who are considered elopement risk have an ID on their persons. She stated she does not feel resident #3 and #4 are true elopement risks as they did not leave the property of the community and staff did proper procedures after they knew the residents were missing. She stated they both are new residents, and the staff is getting to know them. During an interview on at 12:15 pm with family member of resident #4, stated he was never notified when resident #3 eloped from the facility. He stated he was informed when he came to visit a day or two later. He stated she had exit seeking behaviors at home and the facility was aware of this before admission into the facility. He stated that is why she was placed into the memory care unit to keep her safe. He stated the facility was aware she gets agitated especially around sundown and that is time to watch her closely. He stated the facility does not keep him alerted to her behaviors or that she needed to	A 025		

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A 025	Continued From page 5 change medications to keep her calm. He stated the facility lacks the proper supervision to run a memory care unit. During an interview on at 1pm with Staff F, she stated both resident #3 and #4 were exit seeking from day one and can get agitated in the moment. She stated the windows do not have locks on them and can be opened easily. She stated they do not have alarms in the memory care unit on the windows or doors. She stated both residents were elopement risks and should have been more closely supervised and a care plan put in place for interventions for elopement and . She stated she is not aware of any interventions put into place before or after the elopements. Photographic evidence taken Class II	A 025		