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
	AL11969591	A. BUILDING: _____ B. WING _____	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERTUS WL OPCO LLC	11120 LAKE UNDERHILL ROAD ORLANDO, FL 32825

(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 Investigation #2025005144 and a generator monitoring was conducted at Certus WL OPCO LLC. Assisted Living and Memory Care on . The facility had a deficiency at the time of the survey 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	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 3 sampled residents (#1) to prevent elopement from the secured Memory Care unit. Findings: An incident report dated at 3:20 PM documented that resident #1 eloped from the Memory Care secured facility and was missing for about one hour. The resident was found by the Administrator about mile from the facility sitting under a tree with packed water and	A 025		

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A 025	Continued From page 2 snacks. At 3:10 PM, the front desk concierge received a telephone call from the husband that his wife (resident #1) called him and stated she had left the facility. Resident #1 told him that she had left out of bedroom window. At 3:15 PM, the facility had implemented a search (code purple) inside the entire facility. It was concluded that resident #1 was not in the facility. At 3:20 PM, the Administrator found resident #1 about mile down the street from the Memory Care secured facility under a tree, near a residential community fully clothed with water and snacks. Resident #1 appeared to have no visual injuries and resident #1 denied calling 911 and waited for her husband to come pick her up and take her to the emergency room to be checked over. A review of resident #1's record revealed an admission date of (last year). The 1823 Health Assessment dated listed medical history of , , disturbance, disturbance and , acute , , , of skin ( ), , and diffuse , . Her status was frontal damage affecting behavior including stability and aggressive behavior. She needs supervision with activities of daily living in ambulation and bathing. She needs assistance with the self-administration of medications. A facility note dated at 5 PM by Wellness Director documented notifying the physician that resident #1 eloped from the community today. The resident declined the	A 025		

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A 025	Continued From page 3	A 025		

community to contact 911 but did agree to allow her husband to take her to urgent care. No injuries were noted or not visibly seen but the resident #1 did complain of some left ankle , . She said , level 2 out of 10. The resident is currently at Urgent Care with her husband.

A facility note dated at 10 PM by the Wellness Director documented that resident #1 returned to the community from Urgent care. She had checked out good with no injuries. No new orders.

A facility note dated at 10 AM moved resident #1 from her prior to an inside courtyard due to the elopement.

A facility note dated at 1:33 PM by the Wellness Director documented resident #1 being monitored for a recent elopement. Spoke with resident #1 regarding her feelings of being remorseful for exiting the community. The resident #1 voiced a little concern of generalized , and requested , 650 milligram (mg). The Mental Health , , was here this week, and a licensed clinical psychiatrist is coming to see resident #1 next week. The primary care physician was also in the community this week and followed up with the resident #1. Resident #1 remains in a courtyard room and stated that she liked the room. Increased involvement in activities being offered and accepted. The resident has exhibited zero exit seeking behaviors at this time.

On at 2:45 PM, an interview with resident #1 said that she had planned her escape from the facility. Resident #1 said she went out of her window (then) after she had received her 2 PM medication because she knew that was the best time to get away. Resident #1

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explained that she packed some water and snacks and climbed out of the window and walked about mile down the road on the sidewalk near the residential community and when the sidewalk ended, she stopped under a tree to call her husband. Resident #1 said that because she had escaped last month, the facility moved her into (an inside room, window facing courtyard). Resident #1 further explained that she is one of the youngest residents at the facility and still very independent and can do for herself, but she had a , , about 27 years ago that , her memory at times. Resident #1 said that she was a retired nurse, so she knows her medications and what is going on. Resident #1 said that she has good days and bad days and that she misses living at home with her husband, but the family decided that it was safe for her to live in the facility. Resident #1 explained that she was riding her bike and as she was going down a hill, a dog out of nowhere jumped out at her and she was thrown off her bike headfirst. Resident #1 said that was all she remembered and woke up in the hospital. Resident #1 said that the facility has already accommodated her and put a garden tray to plant in the courtyard, literally outside her bedroom window. Resident #1 thanked me for coming and speaking with her and said she did feel remorseful about escaping the facility last month and hope she did not get the facility in any trouble. It was explained that "no" you did not get the facility in trouble. The agency wanted to come and make sure that she was safe. During this interview, observed resident #1 wearing her elopement and medical pendant.

On at 3 PM, an attempt telephone interview with resident #1's husband. No answer left voicemail message. No returned call .

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A 025	Continued From page 5 On at 4:30 PM, an interview with the Administrator disagreed with the finding and further stated that the facility will fight the deficiency because this was the first and only time resident #1 eloped from the Memory Care secured facility. (Photographic Evidence Obtained) Class II	A 025		