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
	AL11966840	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGLISH ESTATES ALF	1340 OXFORD RD MAITLAND, FL 32751

(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 survey (CCR# 2025006053) and generator monitoring were conducted at English Estates Assisted Living in Maitland Florida on . The facility did have deficient practices at the time of the survey.	A 000		
A 025 SS=D	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		

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
	AL11966840	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGLISH ESTATES ALF	1340 OXFORD RD MAITLAND, FL 32751

(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 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 record reviews and interviews, the facility failed to know the whereabouts of 1of 6 of its sampled residents (#1), for the incident which occurred on . Findings: On at 1:00pm resident #1's health assessment form 1823 revealed an admission date of . Resident #1's 1823 was signed and dated . Resident #1's medical diagnosis stated, Unspecified , disturbance, , , ( ) , type 2 , .	A 025		

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
	AL11966840	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGLISH ESTATES ALF	1340 OXFORD RD MAITLAND, FL 32751

(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 025	Continued From page 2 . Resident #1's 1823 also stated that she was an elopement risk. Resident #1's ADLs stated that she was Independent with ambulation, eating, grooming, toileting, transferring and supervision was needed with bathing and On at 10:30am employee A was asked if she remembered the event which happened on the evening of with resident #1. Employee A stated that resident #1 was sitting at the dining table with the other residents. Resident 1 stated that she was going to go visit her mother. Employee A stated that she did not think anything of it and just said Okay. Employee A stated that resident #1 got up from the table. Employee A stated that resident #1 was going to her room. Employee A stated that at about 5:05pm she could not locate resident #1 in the house. At about 5:15pm the doorbell rang, and it was the police with resident #1. The police stated that resident #1 had walked two houses down and knocked on the door saying she was there to see her mother. The homeowner called the police to let them know a resident from the ALF had gotten out. Employee A stated that she called the administrator who then came to evaluate the resident #1. On at 11:06am the administrator was asked what happened on at approximately 5:00pm, she stated that she got a phone call from employee A. Employee A stated that resident #1 had gotten out of the facility. A homeowner called the police who stated that a resident from the ALF had gotten out and did not know how to get to her home. The homeowner stated that resident #1 stated that she was there to visit her mother. The administrator stated that resident #1 is normally	A 025		

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
	AL11966840	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGLISH ESTATES ALF	1340 OXFORD RD MAITLAND, FL 32751

(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 025	Continued From page 3 pleasantly , she enjoys coloring and doing word finds. The administrator stated that resident #1 has never displayed exit seeking behaviors, nor has she ever mentioned anything about her mother. At 12:30pm the administrator was asked if the employees were trained on elopement procedures and does, she conducts elopement drills within the facility, she stated yes, she conducts drills at least every three months. The administrator was asked what had been put in place so that the resident cannot elope from the facility, she stated that she had implemented a door camera and placed cameras within the facility. The administrator was made aware that the facility must make sure that all employees should always know the whereabouts of its residents. At 1:45pm the administrator did confirm that resident #1 was able to leave the facility without the staff having knowledge of her leaving. Class III	A 025		