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
	AL11966519	A. BUILDING: _____ B. WING _____	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBIANCE AT MAITLAND	740 NORTH WYMORE ROAD 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
ZZ821	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.	ZZ821		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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ZZ821	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	ZZ821		

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ZZ821	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	ZZ821		

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ZZ821	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 submit an adverse incident report to the State Agency within 1 business day after the incident, and 15 calendar days after the occurrence of an incident for 1 of 2 sampled residents, (#1). Findings: Review of resident #1's record revealed facility admission on . A health assessment 1823 form dated indicated history of , , , vision, and hearing. The assessment noted the resident ambulated with a walker, and needed assistance with activities of daily living, ambulation, bathing, , toileting, and transfers. The resident was identified as a risk. Review of the incident report showed the event occurred on . The incident report was submitted to the State Agency on , twelve days after the incident occurred. On at 2:37 PM, the Administrator stated she did not submit the report as she was	ZZ821		

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ZZ821	Continued From page 4 still investigating the incident. (photographic evidence obtained) Unclassified	ZZ821		
A 000	Initial Comments Complaint investigation #2025012247 and generator monitoring surveys were conducted at Ambiance at Maitland Assisted Living and Memory Care on and . The facility had deficiencies at the time of the survey. Class I deficiencies were identified for A0025 and A0030. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. The Class 1 noncompliance began on . A0025 Resident Care - Supervision The facility failed to provide supervision to prevent a with injuries for 1 of 2 residents who required assistance with care, (#1). A 0030 Resident Rights and Facility Procedures The facility failed to honor residents' rights providing a safe environment on a sampled residents who were neglected and left outside in 99-degree weather for 2 hours.	A 000		

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A 000	Continued From page 5 The facility's Administrator and Business Office Director was notified of the Class I noncompliance on at 3:35 PM, via phone. The census at the start of the survey was 68.	A 000		
A 025 SS=J	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		

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A 025	Continued From page 6 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 observation, interview and record review, the facility failed to provide adequate care and supervision to prevent with major injury for 1 of 2 sampled residents, (#1). Findings: Review of resident #1's record revealed she was admitted to the facility on and resided in the memory care unit. A Health Assessment 1823 form dated indicated medical history of , , , , , , , , vision, and hearing. The assessment noted the	A 025		

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A 025	Continued From page 7 resident ambulated with a walker, and required assistance with ambulation, bathing, toileting, and transfers. The resident was identified as a risk. An incident report dated showed resident #1 was observed lying on her right side on the ground outside patio. The resident did not respond when her name was called and was noted with hematoma to right temple/forehead. She was assisted to a wheelchair and was subsequently transferred to Orlando Regional Medical Center (ORMC). A report from Maitland Fire Rescue Department dated showed they received a call from the facility at 4:45 PM and responded to the facility for a . Upon arrival, they found the resident sitting in a wheelchair, covered in , with a Glasgow Scale (GCS) of 6 out of 15 that indicated severe level of , . Facility staff informed the emergency personnel the resident was found on the ground outside. The staff did not know how long she had been outside or how long she had been on the ground. The weather at that time was sunny and approximately 96 degrees. The resident's was wet from staff attempting to cool her with water. Resident #1 was placed on a stretcher for further assessment and shortly after. Her skin was red, mottled, hot to touch, and dry. Vitals were obtained: , saturation was 70% on room air, , rate was 14 and shallow, , and temperature was 102.9 by axilla. A hematoma was noted on the right side of her . A sunburn was noted on the resident's , , and arms. The resident's airway was suctioned, her clothes were removed, and ice packs were placed to the and armpits.	A 025		

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A 025	Continued From page 8 were assisted via bag-valve mask, was established, and fluids were administered. and were administered for secondary insufficiency. The resident was successfully intubated and transported to the hospital. On according to the weather channel.com the record high temperature reported as 99 degrees Fahrenheit. https://weather.com/weather/monthly The ORMC hospital inpatient report dated at 5:25 PM, read, female was admitted to the hospital for acute . It was reported the resident was found outside of the facility for 2 hours. Emergency Medical Services ( ) arrived and intubated the resident enroute to the hospital. There were no acute or . The patient was noted to be and met criteria. The resident was started on . She was extubated on without any issues or complication. The resident began having episodes of . On , she was to her baseline. The family requested a hospice consultation The 1st and 2nd shift staff were interviewed to determine how resident #1 gained access to the outside, uncovered patio area and to determine the protocol for supervision when a resident was outside. On at 10:47 AM, caregiver B stated, the incident did not occur on her shift 7 AM - 3 PM. "I'm not sure how resident #1 got outside. If we take the residents outside, we stay with them and make sure they're ."	A 025		

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A 025	Continued From page 9 On at 11:16 AM, the Activities Assistant said resident #1 could move herself around, but "I've never seen her open the door to let herself out onto the patio. When I left around 2:30 PM, resident #1 was sitting in the common area with resident #8". On at 11:27 AM, the memory care Wellness Coordinator stated normally when the residents were outside they were checked on. "I'm not sure what happened that day. Since the incident, we have kept the residents in the common area so that we can watch them". On at 2:26 PM, resident #1's daughter stated "I can only tell you what was told to me by the paramedics and the doctor at the hospital. The Paramedics estimated she was outside for 2 hours." The daughter explained the resident hit the top of her and right side of forehead when she . She explained, "because she was lying in her own , she had to be intubated enroute to hospital. It was 96 degrees outside, on Sunday . Nurse D, who called to report the incident, was unable to answer my questions when I asked how this happened. She was in a wheelchair and could not have wheeled herself outside. She was admitted to the hospital as "Jane Doe" because nurse D was unable to tell the paramedics my mother's name saying she was new to the facility." The daughter added, "the doctor told me she is dying due to the . She will be placed on long term hospice once she's discharged from rehab, not returning to Ambiance." On at 2:54 PM, Licensed Practical Nurse (LPN) D stated, "I'm not sure how she got outside. The last time I saw resident #1 was around 1:30 - 2:00 PM in the memory care	A 025		

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A 025	Continued From page 10 common area participating in an activity. Resident #9 came inside from the patio area stating, the resident who shuffles her has outside on the patio. I called the other staff, and we went outside to resident #1. She was lying on the ground." On at 3:05 PM, Caregiver E stated, "I was not assigned to a hallway. I was running late that day. So, I rushed in to count the medications with Caregiver F and to get on the medication cart. The first time I saw resident #1 was when caregiver H asked me to assist with getting resident #1 from the patio. I wanted to know what happened first before getting resident #1 up. Nurse D kept telling us to get her up, frantically. So, that is what we did and put her in the wheelchair. The patio door locks at 5 PM, so if you don't get in before you're locked out and management must let you in. The other caregivers should have been doing their rounds when they arrived because that's what we're supposed to do." On at 3:32 PM, Caregiver F stated, "I work the 7 AM to 3 PM shift and did not take resident #1 outside. I'm not sure how she got outside. The last time I saw her was at 3:00 PM, she was sitting in her wheelchair at the table with resident #8." On at 4:00 PM, Caregiver G stated, "I work the 7 AM -3 PM shift and did not take resident #1 outside. After lunch resident #1 was changed with assistance from Caregiver F and returned to her wheelchair to the common area near the TV with resident #8. We used resident #1's wheelchair the entire shift that day. We keep the door to the patio locked and keep an on all the residents. We haven't taken the residents	A 025		

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A 025	Continued From page 11 outside since the incident because it's too hot." On at 4:45 PM, the Administrator stated "I did an investigation and obtained statements from the staff. I began putting together a checklist on Monday, . Nothing was put in place after the incident on and we just started the checklist on Tuesday, as we're still investigating." Review of the Resident Sign Off checklist dated for Memory Care included the residents' name, and all 3 shifts, following time and location. Based on review of the document it revealed no checks were conducted on the 7 -3 shift. On 3 PM - 11 PM shift, resident #9 was checked at 6:45, bed, and 11 PM - 7 AM shift at 6:45 living room. There was no further documentation provided indicating the residents were checked on greater than 3 times per day. On at 5:13 PM, Caregiver H stated, "I've never seen resident #1 walk. When I arrived on I saw resident #1 and resident #9 sitting outside on the patio, but I stayed inside to start changing residents. Resident #9, who lives on the purple hallway came in and told Nurse D that a lady was sleeping outside. Nurse D was sitting at the desk and told me to go outside to check on the resident. As soon as I stepped outside, I said it's hot, it's too hot for the residents to be outside. Resident #1's was droopy, and she was slouched in a chair. I was trying to get her up but couldn't do it by myself. So, I went inside to get some help and ask Caregiver E to come outside. When we returned outside Nurse D was standing there appearing frantic, panicking, as resident #1 was now lying on the ground. Nurse D called the paramedics, and they arrived at 4:42 or 4:47 PM."	A 025		

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A 025	Continued From page 12 On at 9:47 AM, the Administrator escorted the surveyor to the activities area where the exit door to the patio was located. The Administrator stated, "We changed the lock system to open the door at 8 AM and close by 1 PM, during the high heat of the day after resident #1's incident." An attempt was made to push open the door and it was locked. Appearing puzzled, the administrator stated, "it should already be unlocked and proceeded to use her key to unlock the door." The Maintenance Director was contacted by phone, who stated he would review the system. He stated it showed as unlocked and later arrived to check the door. The Administrator was asked if resident #1 would have been able to push the door open if she was in a wheelchair. She replied, "I'm not too familiar with resident #1 and can't say for sure if she is able to walk on her own or require the use of a wheelchair. I would have to ask the Wellness Coordinator." Further observation of the patio area revealed a covered area immediately exiting the doors and a 2nd open area with direct sunlight exposure. The Administrator was not able to identify the area resident #1 was found. "She stated, honestly, I'm not sure. Based on what I was told by the staff who found her. I would have to say she was out there (pointing to the 2nd area) in the direct sunlight because they said they needed to get her out of the sun to try and cool her down." On at 10:13 AM, resident #9 stated "I don't recall that day when resident #1 was lying on the ground. I don't recall coming inside telling anyone. The staff won't let us out there now and they don't take us out. I used to go out there anytime and could open the door myself." On at approximately at 10:30 AM the	A 025		

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A 025	Continued From page 13 memory care Wellness Coordinator stated after the incident, the doors were locked not allowing anyone outside. She further stated we don't even allow families visiting to take the residents out on the patio. On at 9:47 AM, the Administrator contradicted the memory care Wellness Coordinator's statement and said the facility, "changed the automatic door system to open at 8 AM and lock by 1 PM. Before the doors would open at 8 AM and close by 5 PM." It was pointed out to her that when the door was tested at 9:47 AM, the door was locked. The Administrator confirmed the door should be unlocked at this time. The facility failed to immediately initiate an investigation to determine how resident #1 gained access to the outside patio area. There were no documented measures in place indicating frequent checks (no specific time i.e... every hour or every half hour) prior to resident #1's incident. The staff stated the residents were kept in the common area. Observations during the 2 days during survey revealed residents around going to hallways where no staff were visibly present and not in the common area. If the residents were left unsupervised, they were still able to go outside once the doors opened at 8 AM placing them at risk for heat related illness. On at 3:35 PM via phone, the Administrator and Business Office Director confirmed the findings. (photographic evidence obtained) Class I	A 025		

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	AL11966519	A. BUILDING: _____ B. WING _____	08/20/2025

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A 030	Continued From page 14	A 030		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the	A 030		

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A 030	Continued From page 15 facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State	A 030		

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A 030	Continued From page 16	A 030		

of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when

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A 030	Continued From page 17 prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.	A 030		

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A 030	Continued From page 18 (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and Rights Florida.	A 030		

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A 030	Continued From page 19 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Base on record review and interview, the facility failed to honor resident rights by failing to ensure 1 of 3 sampled residents were free from neglect when left outside in the heat, unsupervised and suffered heat related illness resulting in transfer to the hospital, (#1). Findings: A record review of resident #1, who resided in a memory care unit revealed a facility admission date of . A 1823 health assessment form indicated medical history of , , , , vision and hearing. The assessment showed she	A 030		

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A 030	Continued From page 20 ambulated with walker, and required assistance with ambulation, bathing, ␣, toileting, and transfers. The resident was identified as a risk. An Orlando Regional Medical Center (ORMC) report dated at approximately 4:30 PM, noted resident #1 was found on the ground, unresponsive in the courtyard of her assisted living facility. She was estimated to have been outside for approximately 2 hours before being found. She was with temperature of 102 degrees Fahrenheit. The facility's , neglect, and , policy dated showed the Administrator would investigate any reports of , neglect, , or other wrongdoing. If a report of , neglect, , or other wrongdoing is received: the administrator or other designated representative will immediately initiate an investigation. A report is made to the appropriate licensing/regulatory agency, the responsible party. A facility note on at 3:25 PM read, 'spoke with daughter who states, resident is currently at ORMC being treated in waiting to be downgraded to progressive care unit, currently has a ␣ and , , .' On at 7:30 PM, Licensed Practical Nurse (LPN) D documented, resident observed lying on right side on ground of outside patio. The resident, without response when her name was called, assisted to the wheelchair. Hematoma to right temple/forehead noted. 911 called. On at 10:47 AM, Caregiver B stated "it	A 030		

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A 030	Continued From page 21 didn't happen on my shift, 7 AM- 3 PM. If it's too hot, we don't take the residents outside." On at 11:27 AM, the memory care Wellness Coordinator stated, "I'm not sure what happened that day. Normally when the residents are outside they are checked on. Resident #1 has an unsteady gait, and we made the decision to put her in a wheelchair." On at 2:26 PM, resident #1's daughter stated LPN D had called her and left a message saying her mother had wheeled herself outside on the patio to get some sun, had a and hit her . "That's impossible because they keep the doors locked. Someone would have had to wheel her out there." On at 2:54 PM, LPN D stated the last time "I saw resident #1 they were doing an activity in the common area when I left to go to the assisted living building between 1:30 PM - 2:00 PM. When I returned it was after shift change and resident #9 came inside and told us resident #1 had ." On at 3:05 PM, Caregiver E stated, "I was not assigned a hallway that day. I arrived late at work, around 3:30 PM and started on the med cart. I did not see resident #1 until I was asked to come and assist her off the ground on the patio," On at 5:13 PM, Caregiver H, stated "when I arrived at work, after 3:00 PM, I saw resident #1 and resident #9 sitting outside on the patio but I stayed inside. Resident #9 came inside and told us that resident #1 was sleeping outside. As soon as I stepped outside, I said It's too hot for the residents to be outside. Her was droopy, and she was slouched in a chair. I was	A 030		

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A 030	Continued From page 22 trying to get her up, but I couldn't lift her. I then went inside to get some help." On according to the weather channel.com the record high temperature reported as 99 degrees Fahrenheit. https://weather.com/weather/monthly On at 9:47 AM, the Administrator was asked how resident #1 was able to take herself outside. She responded, "I'm not too familiar with resident #1 and can't say for sure if she is able to walk on her own or requires the use of a wheelchair." The Administrator did not explain why an investigation was not done to determine how the resident got outside and how she was left outside in the sun and heat for 2 hours without anyone monitoring her. On 3:35 PM via phone, the Administrator and Business Office Director confirmed the findings. (photographic evidence obtained) Class I	A 030		