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 _____	08/21/2025

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 investigation #2025009985 and generator monitoring were conducted on at Legacy Pointe at UCF, Oviedo. A deficiency was found at the time of the survey.	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 record reviews, observations and interviews, the facility failed to ensure the general awareness of the residents whereabouts for 1 of 2 sampled residents (#1). Findings: A review of resident's#1 health assessment dated confirmed a medical history of , ambulatory without assistive devices, alert and oriented x2 with and paranoia at times. The resident has a history of , and resides in the secure memory care unit. The resident is assessed to be an elopement risk	A 025		

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A 025	Continued From page 2 A review of the incident report dated revealed at 3:48pm staff were doing rounds and noted that the resident was walking outside of the memory care unit in the parking lot. The resident was walking along the sidewalk slowly. She was redirected to the facility the resident denies , , no injuries. A review of the incident report dated revealed: On 4:55pm staff noted keypad alarm on door was beeping, however the loud screamer alarm was not going off. Staff checked outside and surrounding area but did not see anyone. Staff were directed to do a count, and it was determined that resident#1 was missing. While in the middle of conducting a room to room search a call was received from a store mile from the facility. The facility guard gate down the street called and notified the staff that they had resident#1. Resident #1 was then brought to the community. One on one supervision was initiated. Review of the admission evaluation dated -revealed a history of . Review of resident #1's individual service plan (ISP) dated states resident requires safety check to ensure that identification is on resident. The resident is to have one on one supervision due to being an elopement risk. Staff are to keep , on the resident at all times. If the resident is in her room, then the staff can remain outside the door. Review of the confirmation receipt of installing sounder and strobes for exit egress door was dated .	A 025		

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A 025	Continued From page 3 Review of the facility's elopement definition- states elopement occurs when a resident leaves the premises or a safe area without authorization and or necessary supervision to do so. Any resident who has , decision-making ability and intent on leaving the facility will be identified upon admission and appropriate interventions will be implemented to reduce the risk of elopement. All emergency exits within the memory unit are equipped with alarms that will sound when the door opens. Alarms are monitored regularly in the preventive maintenance program. Missing residents will be located as quickly as possible. Conduct searches in facility and outdoors. 9:45am Observation of the memory care exit door, confirmed the exit door used by the resident to exit the facility leads to a stairwell with another exit door that opens without any use of security keypad or alarm sounding off. This exit door leads outdoors to the parking lot of the facility. Observed the screamer alarm was in the process of being fixed. At the time of the observation the screamer alarm was enabled and sounded off when the egress door was pushed. 9:55am Observation of resident#1 revealed she was , around the secure memory care checking doorknobs on resident rooms. Staff then came and redirected her to the common area. Resident#1 was wearing an identification on her . At 10am on 8/2102025 staff A stated the exit door near her room and had an alarm that the staff could not hear, especially if they were attending to other residents in their rooms. She stated resident#1 is a . She explained after the elopement resident#1 was placed on one-to-one supervision until the egress door was fixed with a	A 025		

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A 025	Continued From page 4 loud screamer if someone tries to exit from the door without using the keypad. Staff A stated the resident was found past the front gate at a dollar store. She stated it is approximately ½ mile away. At 10:15am on staff B stated at the time of the elopement the exit door had a very faint alarm that staff could not hear if not near the door. He stated all someone had to do was push the exit handle of the door for 15 seconds and the door automatically opened. He stated the county finally allowed the facility to adjust that. He stated now if someone pushes the exit door handle a loud screamer alarm goes off. He stated the staff must use a key code to get out of the exit door. At 10:30am on staff C stated resident #1 likes to about the memory care unit and always wants to be with her husband. She stated the resident would usually call him on the phone. She stated the exit door had an alarm that could not be heard throughout memory care. She stated that is how resident#1 was able to leave without being noticed. She stated resident#1 was placed on 1 to 1 supervision after the incident. 10:50am on staff D stated resident #1 has always been a and will tell staff she needs to get to work, or her boss will be mad. She stated we redirect her all the time. She stated most of time resident#1 likes to walk around the memory care. She stated she has never eloped before but will try to see if she can leave out the door. She stated she has completed elopement drill 2x per year. 12pm on the Administrator stated he has only been here for 5 weeks and is not aware of what transpired with the elopement.	A 025		

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A 025	Continued From page 5 12:30pm on the Nurse Manger stated the egress door did not have a loud alarm on it and that is why the staff did not hear the resident leave. She stated since then that now there is a screamer on it that is loud enough for the whole memory care unit to hear if someone should go through the door. She stated at the time the door did have a screamer, but it was not loud enough for staff to hear. She stated the exit door was beeping at the time and the staff immediately checked outside and surrounding area but did not see anyone. count was done, and resident#1 was missing from the count. She stated she then received a call from the dollar store down the street who informed her that the resident was there. She stated she and security went to dollar store to retrieve her and bring her to the memory care unit. She stated resident#1 was placed on 1 to 1 supervision until the screamer on the exit door was placed. She stated that only resident#1 is an elopement risk at this time for the assisted living side and memory care. She stated resident#1 has a history of ˬ and wanting to elope. She stated she takes her identification bracelet off frequently and we place it on when we notice it missing. at 12pm the family member of resident#1 stated that resident#1 is always trying to leave the facility. He stated the staff should be always supervising her and they are not. He stated most of time the staff stays in the common area while she is ˬ around or trying to get out of her windows in her room. He stated this elopement has happened too many times and the facility is not ˬ her needs to prevent it. He stated they never addressed it when they made the care plan or at admission how they would give more supervision attention to her. He stated she is constantly trying to leave the facility	A 025		

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A 025	Continued From page 6 through doors or windows, and nothing is changing to prevent her eloping again. 12:15pm on Staff G stated she was on duty when the elopement occurred. She stated resident #1 was acting out behaviors and was placed on one on one. She was then taken off one-on-one supervision, (she does not recall the times and dates) when the behavior subsided. She stated when the resident was off one on one supervision that is when she attempted to elope out the exit door. She stated the alarm was on the exit door and so staff did not hear her leave. She stated the resident is always packing her items everyday to leave the facility. She stated the resident needs one on one supervision on a daily basis but the family stated they can't afford it. She stated she is constantly informing management that resident#1 needs 1one on one supervision, but nothing is ever done about it. Photographic evidence taken Class II	A 025		