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
	AL11969022	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING FACILITY	2250 S SEMORAN BLVD ORLANDO, FL 32822

(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 (2025014525) and a generator monitoring were conducted at Assisted Living Facility on and . The facility had a deficiency 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 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 (a) Monitoring of the quantity and quality of 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 supervision when 1 of 4 sampled residents was taken out of the facility by an unauthorized person and the same resident eloped from the secured memory care unit (#11.) Findings: A review of resident #11's record revealed a facility admission date to the secured memory care unit	A 025		

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A 025	Continued From page 2 on . A health assessment form (1823,) dated , indicated the resident had a diagnosis of . The form indicated that the resident was not at risk for elopement. A review of a facility note, dated , revealed the Resident Care Director (RCD) documented that the residents' daughter was concerned that an unauthorized family member who visited the resident accessed the resident's bank account and was trying to take the resident to another country. The note indicated that the unauthorized family member told facility staff of their intent to take the resident to her home country as soon as possible. The note indicated the RCD instructed facility staff to obtain approval from the Power of Attorney (POA) prior to allowing the resident to leave with anyone. Review of a POA document, dated , revealed the residents' daughter became the POA. A review of a facility note, dated , revealed the RCD documented that at approximately 10:30 AM, the resident returned from a leave of absence. With her was the unauthorized family member. The note indicated that staff saw the unauthorized family member pack the residents' belongings in suitcases and would not allow staff to enter the residents' room. The note indicated that the POA said resident #11 was not permitted to leave the facility with anyone until further notice. The note indicated that the Administrator then told the unauthorized family member the resident could not leave. The unauthorized family member became upset and barricaded the resident's room with luggage. The note went on to indicate that shortly thereafter, the resident and the unauthorized family	A 025		

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A 025	Continued From page 3 member were no longer in the facility. Law enforcement was contacted and were able to locate the resident and the unauthorized family member at a friend's apartment. Law enforcement returned the resident to the facility approximately an hour and half after she left the facility. During an interview on at 2:05 PM, caregiver B said that she saw the resident and the unauthorized family member walking towards the dining room on . The unauthorized family member had a book bag and suitcase with her. Caregiver B said she was never told the unauthorized family member said they were removing the resident prior to doing it. During an interview on at 10:43 AM, the Administrator said that on at 1:51 PM, he sent a group cell phone message to all staff that the resident's POA did not want the resident to be taken out of the facility. The Administrator said he informed staff via a group message at 4:50 PM that the resident was not allowed to leave for any reason. The Administrator said he also verbally told the receptionist. The Administrator said that despite the notifications, caregiver D let the unauthorized family member and the resident out of the secured memory care unit. During an interview on at 12:17 PM, caregiver D said he was never told the resident could not leave on . The caregiver said he did not recall receiving either group message sent by the Administrator. The caregiver said he recalled hearing staff talk about a resident who was not allowed to leave but he did not know who that resident was and he did not ask.	A 025		

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A 025	Continued From page 4 During an interview on at 1:20 PM, the receptionist said she did not remember seeing the resident and the unauthorized family member leave on . The receptionist said the Administrator told her there was a weird situation going on and instructed her to now allow the resident to leave with anyone. The receptionist said she did not know what the resident looked like. The receptionist then said the Administrator said he would make sure she was given a photograph of the resident, but he never did. During an interview on at 1:59 PM, the resident's POA said that she told the facility administration that the unauthorized family member could visit the resident but was not allowed to remove her from the facility. The POA said she verbalized to administration her fear that the unauthorized family member would take the resident out of the country. A review of video footage and pictures revealed the resident, and the unauthorized family member exited the facility through the lobby on at 5:07 PM. A review of a facility note, dated at 9:45 AM, revealed the RCD documented the POA reported the resident previously lived at another assisted living facility, from where she eloped. A review of the facility's resident elopement policy, dated , revealed the facility defined elopement as a situation where a resident leaves the facility grounds without the staff's knowledge and fails to follow the facility policy for signing in and out and the resident was at risk for injury or sustained an injury.	A 025		

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A 025	Continued From page 5 A review of a facility incident report revealed that on at 5:28 PM, the resident asked to go outside in the memory care courtyard. Caregiver A accompanied the resident into the courtyard at approximately 5:30 PM. The report indicated that at 5:46 PM, caregiver A returned indoors while the resident remained in the courtyard. At approximately 6:26 PM, the resident climbed over the perimeter fence and exited into the facility parking lot. At 6:30 PM, after unsuccessful attempts to open the main entrance, pedestrian, and service gates, she crawled under the service gate exiting the facility grounds. The report indicated that at 6:37 PM, caregiver A returned to the courtyard to check on the resident and noted the resident was no longer there. At 6:40 PM, caregiver A alerted the other staff, who began searching inside the facility. At 6:58 PM, the RCD was notified. At 7 PM, the administrator was notified. At 7:19 PM, the RCD contacted a nearby police officer while in route to the facility. The report indicated law enforcement arrived at the facility at 7:54 PM. The report indicated that law enforcement reported finding the resident at 8:50 PM. The report indicated that law enforcement returned her to the facility at 8:56 PM. The report indicated the resident said she left to go to her former place of residence. During an interview on at 2:05 PM, caregiver B said that on she looked for the resident to give her dinner time medications but could not find her, so she called the RCD. The caregiver said the resident consistently said prior to the elopement that she did not want to be at the facility and that she missed her family.	A 025		

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A 025	Continued From page 6 During an interview on at 2:18 PM, caregiver C said the resident was always very active, would not stand still, and was an exit-seeker. The caregiver said that within a few weeks of the incident involving the unauthorized family member, the resident threatened to jump the fence. Caregiver C stated the resident placed a chair against the fence, but staff intervened. The caregiver said staff were supposed to remain with the residents while in the courtyard. During an interview on at 2:55 PM, caregiver E said the resident was aggressive, combative, and difficult to redirect. The caregiver said that when the resident was in the courtyard, she constantly walked. The caregiver said staff were supposed to remain with residents while in the courtyard. During an interview on at 10:43 AM, the RCD said caregiver A should have remained with the resident in the courtyard when she eloped. During an interview on at 11:24 AM, caregiver A said that the resident was very talkative. The caregiver said the resident had episodes of tearfulness, saying she did not know why she was here, this place was for crazy people, she hated her daughter for putting her here, and her family left her here. The caregiver said the resident offered staff money to take her places. The caregiver said the resident talked about wanting to get out and she watched everything. The caregiver said that when the resident eloped on , she and another resident wanted to go into the courtyard, so the caregiver went with them. The caregiver said that when it was time to set up for dinner, resident #11	A 025		

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A 025	Continued From page 7 became aggressive and refused to go inside. The caregiver said she left the resident alone in the courtyard because she had to set up for dinner and because a co-worker said the resident usually came inside herself. The caregiver said staff were supposed to remain in the courtyard when residents were present. Class II	A 025		