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 |
|---|---|---|---|
| | AL11964824 | A. BUILDING: _____ B. WING _____ | 11/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SAVANNAH COURT OF OVIEDO II | 395 ALAFAYA WOODS BLVD. OVIEDO, FL 32765 |

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| A 000 | Initial Comments<br><br>A complaint investigation #2025013951and generator monitoring were conducted on at Ansley Court & Cottage 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<br><br>429.26<br>(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.<br><br>59A-36.007 Resident Care Standards.<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:<br>(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<br><br>59A-36.012, F.A.C.<br>(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.<br>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.<br>(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.<br>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>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).<br><br>Findings:<br><br>In a review of resident#1's admission and health assessment, confirmed resident #1 was a day care resident at the facility a few times per week, with an admission date of . Review of the health assessment dated revealed a diagnosis of , assistance with medications and assistance with daily living for bathing, self-care, toileting, , and | A 025 | | |

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| A 025 | Continued From page 2<br><br>precautions.<br><br>The resident's record did not contain a care plan or daily observation notes.<br><br>In review of the facility's notes for resident#1's elopement incident, it states on at 4:30 PM the family came to pick up the resident from the facility. Staff went to get the resident from the assigned day room, and the resident was not there. Staff began to search for the resident and could not find her in or outside the facility. Law enforcement was called. The resident was found approximately 1.5 miles from the facility by law enforcement and was brought to the facility. The resident did not incur any injuries.<br><br>In review of the facility's elopement policy states an elopement occurs when a resident who is , , , , or otherwise unable to recognize danger or protect themselves, leaves the community property or grounds without staff awareness or authorization.<br><br>In review of Law enforcement's report dated at 5:22PM. states responded to the facility for a missing person. The resident found 1.5 miles from facility on the sidewalk at 5:30 PM. No injuries reported.<br><br>In a review of the incident report dated , resident#1 was dropped for a day stay at the facility. At approximately 4:50 PM, the resident's family member arrived to pick her up. Staff went to retrieve the resident and was unable to locate her. Staff began a thorough search of the facility, including all bedrooms, showers, closets, offices, common areas, kitchen, outside patios, parking lot, and surrounding grounds. After approximately 15 minutes of unsuccessful searching, law | A 025 | | |

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| A 025 | Continued From page 3<br><br>enforcement was contacted. The resident was located by local authorities at approximately 5:30 PM and returned safely to the facility.<br><br>In an observation of the facility's day room for the day residents, it was observed there were no staff present or supervision available at the time of the observation. Staff were attending to other residents.<br><br>In an interview on at 10:45 AM with Caregiver E, she stated all residents including day residents are checked on every 2 hours. She stated the day residents stay in the activity area if activities are going on or the common area. She stated she did not know resident #1 well and was not aware of elopement behaviors. She stated the day residents, like the other residents, are allowed to go outside.<br><br>In an interview on at 11AM with the Wellness Director, she stated that the day residents are placed in the front common area by the receptionist. She explained they go to the activity room when activities are taking place. The Wellness Director stated she is normally in building however she was not present for the elopement and is not aware of the residents' behaviors if any. She stated the resident has not come to the facility since the elopement. According to the Wellness Director staff followed the protocol when the incident occurred. She explained the staff are aware that all residents are to be monitored and checked every 2 hours. The resident was seen 2 hours prior to the elopement.<br><br>In an interview on at 11:30 AM with Caregiver A, stated resident #1 had never shown any elopement behaviors in the past. She stated | A 025 | | |

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| A 025 | Continued From page 4<br><br>she saw the resident around 2 PM that day. She explained around dinner time at 4 PM she noticed she was not there. She stated they check on all residents every 2 hours. When she realized she was not in the dining area she informed her coworkers, and they began a search of the facility inside and out. The administrator was notified and the administrator called law enforcement.<br><br>In an interview on at 12:30 PM with the activity assistant staff G, she stated resident #1 attended the activity from 3:00 pm to about 3:45 pm and then the resident got up and left and walked toward the dining area. She stated throughout the day resident #1 seemed and kept stating that her daughter will not know where she is and she needs to meet her. She stated she reported this behavior to the administrator, but it is not clear if the administrator or staff put any interventions in place. She stated the last time she saw resident #1 was in the activity center participating in the trivia game, very and wanting to find her daughter to go home.<br><br>In an interview on at 12:45PM with the Administrator, she stated resident #1 is a day service from time to time. She stated she never displayed any elopement or exit seeking behaviors before the incident. She stated the resident stated after the incident that she was going to meet someone and that is why she left. The administrator stated she informed the family after the incident that to remain a day resident she would have to be placed in the memory care unit. She stated the facility does do observation notes on day residents, so there are no observations on her behavior while she was here.<br><br>Photographic evidence obtained | A 025 | | |

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| A 025 | Continued From page 5<br><br>Class II | A 025 | | |