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
	AL11968966	A. BUILDING: _____ B. WING _____	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTRY PARK ORLANDO	3201 CENTER POINT DR ORLANDO, FL 32825

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ZZ821 SS=D	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. Residential Mental Health Providers: Crisis stabilization units, short-term residential treatment facilities, residential treatment facilities, and residential treatment centers for children and adolescents shall submit incidents as required by Section 394.907, F.S., and rules promulgated thereunder to the Agency within 1 business day of occurrence on Residential Mental Health Provider Incident Report, AHCA Form 3180-5008OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-18470, 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 6. 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. 7. For the purposes of this rule, the following applies for submitting adverse incident reports:	ZZ821		

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ZZ821	Continued From page 3 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 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 a preliminary Day 1 report after the incident and full Day 15 report for 1 of 3 sampled residents (#1). Findings:	ZZ821		

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ZZ821	Continued From page 4 In a record review of resident#1's health assessment and admission contract, the resident was admitted to the facility on . The health assessment dated revealed a history of , , , , , , , , , history of falling and mobility. Also, the health assessment documented assistance with activities of daily living which included ambulation, bathing, , transferring and self-care. The resident was noted to be an elopement risk at the time of admission. In an interview on at 10:15 AM with the Regional Director, he stated the Wellness Director admitted to resident#1's elopement which occurred in the evening on . He stated he was informed the resident opened his bedroom window with a screwdriver to take off the window blockers that were left in his room by maintenance. He stated the resident was found with scratches on his arms and . He stated the wellness director was afraid to admit it to this surveyor because she was previously told by the previous administrator to say the elopement never occurred, only that he threw clothes out the window. He stated the resident was never assessed for injuries and the family was informed he threw the clothes out the window. He stated it was never reported to the agency. In an interview on at 12:45 PM, the administrator confirmed the elopement occurred on and the incident was never reported to the agency.	ZZ821		
A 000	Initial Comments	A 000		

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A 000	Continued From page 5 A complaint survey (#2025015390) was conducted on at Gentry Park Assisted Living, Orlando. Deficiencies were found at the time of the visit.	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 6 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, record reviews and interviews, the facility failed to ensure the safety, physical and emotional well-being of the resident, maintained a general awareness of the resident's whereabouts and contacted the resident's health care provider and the resident's family member with accurate information for 1 of 3 sampled residents (#1). Findings: In a record review of resident#1's health assessment and admission contract, the resident was admitted to the facility on . The health assessment dated revealed a	A 025		

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A 025	Continued From page 7 history of , , , , , , , , history of falling, , mobility. It also confirmed assistance with activities of daily living which included assistance with ambulation, bathing, , transferring and self-care. The resident was noted to be an elopement risk at the time of admission. Resident#1 resided in the memory care unit. Resident#1's record revealed no observation or facility notes. In addition, there was no facility note of the elopement that occurred on . A health assessment completed on , after the elopement incident did not document the resident was an elopement risk. In an observation of the memory care unit, the bedroom units had blockers on all the windows and could only be opened approximately 2 inches. In an interview on at 10 AM with the Wellness Director, she denied the allegations of an elopement and stated the resident only threw clothes out the window. She emphatically stated the elopement did not happen and it must have been a disgruntled employee or family member that made this up. She stated she informed the spouse of the resident that he only threw clothes out the window. She stated she never notified the resident's physician. In an interview on at 10:15 AM with the Regional Director, he stated he just found out from the Wellness Director the elopement did occur on at 7pm with resident#1. He stated he was informed the resident opened his bedroom window with a screwdriver to take off the window blockers that were left in his room by	A 025		

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A 025	Continued From page 8	A 025		

maintenance. He stated the wellness director was afraid to admit it to this surveyor because she was previously told by the previous administrator to say the elopement never occurred, only that he threw clothes out the window. He stated the resident was never assessed for injuries and the family was informed he threw the clothes out the window. He further stated the incident was never documented and there are no facility or observation notes for the elopement. He stated the Wellness Director just informed him in private about the elopement.

In an interview on at 10:30 AM with the Maintenance Director, he stated the staff nurse on duty that evening called him to state that the resident threw his clothes out the window. He stated she never mentioned he eloped through the window. When he came in the next morning, he found the window ajar and a screwdriver on the floor. He stated the screwdriver did not belong to the facility and no one knows how he had obtained one. He stated no one informed him that the resident eloped, just that the pillows and blankets were outside the window. He explained the resident had taken the screws off the blocks that were on the window.

In an interview on at 10:45 AM with the Wellness Nurse, stated she was at home after her shift on at about PM, but was not sure of the time, when a staff person from memory care called (stated she could not remember the staff person's name) to say that resident #1 opened his bedroom window and threw his clothes and blanket out. She stated she never heard the resident eloped. She stated she called the Wellness Director to inform her and then called the maintenance director to inform him he needs to get the window repaired. She

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A 025	Continued From page 9 stated she does not remember the time or the staff members' name that called her. She stated she could hear the resident's voice in the background. She stated she did not document the phone call, and she has no documentation of the incident. She stated she remembers very little of the incident. In an interview on at 11 AM with the Wellness Director, she stated she denied the allegation of elopement because the previous administrator told her not to say anything and just tell the family the resident only threw his clothes out the window. She stated she doesn't remember the dates or times the elopement occurred. She stated no one documented the incident and it was not reported to the agency. She stated staff C informed her that evening of the incident that the resident opened his window and climbed out. She stated the resident was found by a staff person and brought outside. She stated she does not remember any of the times of the occurrence. She stated she did not inform the family of the incident and only told the spouse of resident#1 that he threw the clothes out the window. She admitted the resident was never assessed for injuries and no facility notes were completed. In an interview on at 12 PM with resident#1's spouse, she stated she came into the bedroom the next day and the maintenance director stated that he was fixing the window screen due to fire regulations. She stated he never informed her it was because her husband tried to get out of the window. She stated she was informed by the Wellness Nurse that her husband was throwing clothes and blankets out the window and used a screwdriver to pry the window open. She stated the screwdriver found in his	A 025		

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A 025	Continued From page 10	A 025		

room, she believed was left by maintenance as her husband never had a screwdriver of his own in the facility. She stated she has gotten multiple stories from staff and never found out the truth about the incident. She stated when she came to the facility the next day her husband told her he left through the window and came into the facility at the front entrance. She stated he had small scratches on his ˬ and arms which she believed came from falling in the bushes outside of the resident's window. She stated she took him out of the facility on as she did not think the facility was supervising him properly and he could have been seriously hurt during the elopement. She stated she was very disturbed by how the Wellness Director and staff never told her the truth about the incident and he was never assessed for injuries.

In an interview on at 9:15 AM with staff A, she stated she was working the memory care unit that evening of the elopement and verified resident#1 did elope out of his bedroom window by using a screwdriver to take the blocks off. She stated a staff person noticed him outside of the facility and radioed for assistance and then brought him into the facility through the front reception doors. She stated she does not remember any times or what staff were involved. She stated she is not aware if any staff documented the incident. She stated the resident was always restless, agitated and wanted to go home. She stated he was checked on every 2 hours and is not aware of the time the incident occurred only that it was on her shift. She stated he was ˬ but slow to respond to directions or questions. She stated the Wellness Director was notified by staff and no directions were given other than she would notify the family. She stated she has completed 2 elopement drills for the

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A 025	Continued From page 11 year. In an interview on at 9:45 AM with staff C, she stated resident#1 was an elopement risk but was not designated as one. She stated resident#1 was always agitated and restless and wanted to go home and would say so every day. She stated the memory care windows have blocks on the windows, so they only open a couple of inches. She stated he obtained a screwdriver from somewhere and was able to take the blocks off the windows and get out. She stated the screwdriver was found on the floor of his bedroom where he eloped. She stated staff spotted him outside (not sure of any times or what staff) and he was brought into the facility through the front doors. She noticed he had scratches on his arms and which most likely came from the bushes outside his bedroom window where he got out from. When the resident was spotted outside, she called the Wellness Director and the Wellness Director stated she would notify the family. There were no other directions given by the Wellness Director. In an interview on at 12:45 PM with the administrator, he confirmed the incident of the elopement happened as the Wellness Director admitted to it today. He stated he could not find any facility or observation notes on the incident. He stated he just started the job recently and was not aware the elopement occurred. He stated he is asking his management to dismiss all the staff involved in the incident. He stated he was very disturbed by the fact the staff hid this incident from family and the agency. Photographic evidence obtained Class II	A 025		

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