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 _____	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSLEY COURT & COTTAGE OVIEDO, LLC	395 ALAFAYA WOODS BLVD. OVIEDO, FL 32765

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ZZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	ZZ830		

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ZZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	ZZ830		

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ZZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on facility's documentation and interview, the facility failed to submit an updated Comprehensive Emergency Management Plan (CEMP) to the local emergency management agency within 30 days after changes were made reflecting the new Administrator and new Maintenance Director for contact and Change of Ownership (CHOW) as required. Findings: A review of the facility's current CEMP written plan and approval letter dated still had the old name Savannah Court II Assisted Living Facility instead of Ansley Court and Cottage Oviedo LLC. effective when there was a Change of Ownership (CHOW). In further review, the CEMP written plan still name the prior Administrator and prior Maintenance Director for contact in case of an emergency. On at 6:30 PM, an interview with the new Administrator confirmed the findings and further stated that she was already working on it and called the Seminole County Emergency Management office to get it updated. (Photographic Evidence Obtained) Class III	ZZ830		
A 000	Initial Comments	A 000		

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A 000	Continued From page 3 There were two (2) Complaint Investigations #2025017593, #2026002076 and a generator monitoring was conducted at Ansley Court & Cottage Oviedo LLC. Assisted Living Facility (395 Alafaya Woods Blvd Oviedo, FL 32765). The facility had deficiencies at the time of the survey 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,	A 025		

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A 025	Continued From page 4 including the following: (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 record review and interview, the facility failed to provide appropriate supervision for 1 of 4 sampled resident (#1) with assessing changes in condition by following the physician's order for a 3rd party to provide service in caring for a , and the facility failed to prevent unintentional loss as required. Findings: A review of resident #1's record revealed date of admission . The last 1823 Health	A 025		

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A 025	Continued From page 5 Assessment dated listed medical history of and dependent. He was forgetful with mild and required testing daily. He needed assistance with self-administration of medications. Resident #1 was discharged on to the hospital due to was found in his briefs (underwear), he on (two months later). His medications listed were , 10 milligrams (mg); 5mg; , 81mg; 30mg; 20mg; Aspart , 100 units, inject 8 units before meals. 10-gram PRN for ; 2mg; 75mcg; 500mg; Rosuvastatin 40mg; Sem glee 100 units, inject 50 units in the morning. 8.6mg; and Tab-a-Vite tablet once daily. In further review, found a physician's order dated for 0.1% to be applied , right lower / area once daily on Monday/Friday. Clean and cover with gauze , Home Health Agency (HHA) to administer. There was no documentation evidence that this order was followed by the facility as required. A facility note on at 11:32 AM by prior Health Wellness Director (HWD) documented called and spoke with resident #1's family about an increase of and signs of potential . Currently resident #1 was only walking on the property and had not eloped. It was explained to avoid elopement the facility was recommending as an option, moving him to the secured Memory Care building or hiring a private	A 025		

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A 025	Continued From page 6	A 025		

sitter to monitor him. The family member said he will come to the facility today and check on the resident with hopes of possibly finalizing the move to Memory Care to ensure his overall safety.

A facility note on at 11:44 AM by prior HWD documented resident #1 was and enjoyed walking the property, resident #1's family came to visit and was hesitant to move resident #1 in Memory Care.

A facility note on at 3:16 PM by prior HWD documented resident #1 was outside and attempted to leave the property. On , the facility had already spoken with the family about resident #1's overall safety from elopement and the need to move resident #1 to Memory Care. The prior Administrator determined that resident #1 to move to Memory Care after today's event with resident #1 trying to leave the property. Notified the family member of the decision by the prior Administrator by leaving a voicemail, as there was no answer. Staff gathered resident #1's personal belongings and moved him to Memory Care for his safety.

The facility moved resident #1 to Memory Care without consent or no authorization from the legal representative family member.

A facility note on at 7:18 PM by the prior HWD documented resident #1 moved from ALF to Memory Care, and notified the family but no answer, left a voicemail message.

A facility note on at 11:03 AM by the prior HWD, resident #1 seems to be adjusting well to the new surroundings in Memory Care.

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A 025	Continued From page 7 A facility note on at 2:45 PM by the prior HWD called resident #1's family members to update them on his move to Memory Care but there was no answer and left a voicemail message. A facility note on at 5:56 PM by the prior Resident Care Coordinator (RCC) documented that on (three days before) at breakfast, resident #1's refused his . Notified physician and left a voicemail message to the family. A facility note on at 6:26 PM by the prior RCC documented she called and left a voicemail message with the physician to go over for resident #1 explaining that readings have been concerning. She also called the family with no answer, leaving a voicemail message for a returned call. A facility note on at 2:20 PM by the prior HWD documented late entry, spoke to the physician about resident #1's elevated . The physician discontinued 5 units of short acting and sent new order for 7 units to the pharmacy. A facility note on at 3:03 PM by the prior HWD contacted the family to advise that resident #1 declined and will have to issue a 45-day notice for medical necessity. A facility note on at 3:57 PM by the prior RCC observed in resident #1's briefs (underwear). Notified the family and called 911. Resident #1 was transported to the VA hospital. A facility note on at 2:37 PM by the facility's Licensed Practical Nurse (LPN)	A 025		

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A 025	Continued From page 8 documented the VA hospital nurse called and informed that resident #1 was not eating. He's opening his , and not making any sounds and now has a and a tube. Notified the family about the update the VA provided. The family said that the VA hospital had been calling him because resident #1 was not eating. A facility note on at 10:33 AM by the facility's LPN called and followed up to VA hospital for update on resident #1, he is on the 4th floor west wing. The VA nurse informed that resident #1 was being monitored on via and still had a and . A facility note on at 11:11 AM by the prior RCC documented the VA hospital called to request resident #1's medication to be faxed over at a secured email address. A facility note on at 10:42 AM by the facility's LPN documented called the VA hospital for update on resident #1, unable to receive update because not family or legal representative. Called the family member and informed that resident #1 was not doing well and thanked them for calling, hanging up. A facility note on at 3:06 PM by the new HWD documented traveled to the VA hospital to visit resident #1. After arrival, the staff at the VA informed us that resident #1 had been discharged on to a skilled rehabilitation facility and no further updates provided. A review of resident #1's log for , and that showed he had a significant loss every	A 025		

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A 025	Continued From page 9 month totaling . See documented details below: -on the 1823 Health Assessment dated signed by the healthcare provider, resident #1's . (pounds). -the facility resident #1 dated (7 days later) and he was . (. loss). -the facility resident #1 dated and he was . (. loss). -the facility resident #1 dated and he was down to . (. loss). There was no documented evidence showing the facility was overseeing resident #1's significant loss and no documentation if the facility was monitoring his food intake such as eating his 3 meals daily and snacks. On at 4:58 PM, an interview with the LPN regarding the physician order for care to his and his significant loss and she answered that she was not aware. The facility's LPN further said that she was not overseeing his care during that time, it was the previous HWD and previous RCC. The facility's LPN stated that resident #1 was one of her favorite resident as sometimes she would sit and have conversations with him about life. On at 5:02 PM, an interview with the Administrator regarding resident 1's almost elopement on and moving resident #1 to Memory Care without consent and authorization from the family first. The Administrator said that she was not aware at that time this decision was made because she was the Business Office	A 025		

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A 025	Continued From page 10 Manager and the prior Administrator made that decision. Furthermore, the Administrator stated that she was not aware that resident #1 had care orders and was not aware that he was losing significant amount of . On at 6:37 PM, an exit interview with the Administrator, Regional Director of Operations and an Administrator from a sister facility was present. The Administrator confirmed the findings. (Photographic Evidence Obtained) Class II	A 025		