AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Pleasantville ALF
609 Oak Avenue
Mount Dora, FL 32757

Dear Administrator:

Re: CCR #2012013192 & #2012013195

This letter reports the findings of a compliance survey that was conducted on . 2013 by representative(s) of this office.

Enclosed is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after . 2013 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call this office at (386) 462-6201.

Sincerely,

Stephen Bergin for,

Kriste J. Mennella
Field Office Manager

KJMamw

Enclosure
XG90

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14101 N W Hwy 441, Suite 800
Alachua, FL 32615-5669
Phone (386) 462-6201; Fax (386) 418-5300

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
	AL11922282	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANTVILLE, ALF	609 OAK AVENUE MOUNT DORA, FL 32757

(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 An unannounced investigation CCR#20120 13192 and CCR#20120 13195 was conducted on . 2013. The complaint was confirmed. Deficient practice was identified, specific to the complaint investigation. The facility is found not to be in compliance with Chapter 429, Part I Florida Statutes and Chapter 58A-5, Florida Administrative Code	A 000		
A 025 SS=D	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, 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 individual. (c) 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; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents,	A 025		

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A 025	Continued From Page 1	A 025		

changes in the method of medication administration, or other changes which resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by:
Based on staff interviews and observation the facility failed to proved supervision, for a resident with , to prevent elopement.

Findings:

A tour was conducted at on 01 at 10:45 AM. The entire facility was toured on the inside as well as the outside. Doorways attached to the facility, for exit to the outside(street), included the front door and a side door(near a utility area) The front yard had no chain-link or other fencing and was completely open to the street/sidewalk area. Access to the front yard could be gained either via the side or the front door. The front door contained a push button locking system. To exit via the front door someone would need to know the code and push the appropriate code buttons. The code was clearly visible just above the door lock mechanism, as it was hand written on a piece of white tape, that was sticking to the door. The side door had a typical brass entry/exit door knob that could be locked from the inside with a thumb latch mechanism. Also on the side door were brass, sliding chain locks. There was one near the top of the door and one located near the bottom of the door, on the inside. Any one could exit to the outside yard through the side door way, if they were able to reach to the top brass, sliding lock, to unlock it.

In interview with the Administrator, on at 11:15 AM, she admitted that the police had brought resident #1 back to her facility on after the police had made contact with Resident #1 some distance away from the facility.

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A 025	Continued From Page 2 The police had thought that Resident #1 was possibly from a nearby ALF. Resident #1 at the time was disoriented and was unable to provide her own name or where she resided. The administrator stated, that on , she had gone into town to conduct some business and had left (2) staff persons in charge. The administrator added, that she and staff would routinely allow Resident #1 to go outside on her own and by herself, over to the circle intersection. She further states, that this circle intersection near the facility is only a short distance away (30 to 40) yards. She indicates, that they would often allow Resident #1 to go to this intersection, to allow her a bit of time away from the facility, so as to provide her some freedom from the facility property. The administrator states, that Resident #1 was always able to walk to the circle intersection and return back on her own. The administrator notes, that apparently on , while she was in town on business, that her staff allowed Resident #1 to walk to the circle intersection, but this time Resident #1 did not return on her own. Based on interview with the complainant, she states that the police told her that when the police had called the Pleasantville ALF, the staff there were unaware that any residents were missing and that they reported to police that all residents there were present. This report from ALF staff caused the police much unnecessary efforts in determining where Resident #1 actually resided at or if she resided in the area at all. The complainant explained, that after considerable time had elapsed, the staff at the Pleasantville ALF realized that Resident #1 was not present or accounted for at their facility and apparently made additional contact with the police and stated that Resident #1 did belong at their facility. Consequently, Resident #1 was returned to the ALF where she resides. According to the	A 025		

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A 025	Continued From Page 3 Administrator, upon return to the facility, Resident #1 was taken to the Physicians office for examination. Class III	A 025		