STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964749	09/18/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Savannah Court Of Oviedo I	355 Alafay Woods Blvd. Oviedo, FL 32765	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= D

Specific Tag Findings:

0000-Initial Comments
unannounced complaint inspection CCR #2013009308 was conducted. Savannah Court of Oviedo I had deficiencies found during the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observations, interviews and records review the facility failed to provide daily observations of the activities of the residents while on the premises and the general awareness of the resident's whereabouts for 1 of 3 sampled residents (#1) who had a history of elopement.

Findings:

Published on , 2013 11:17:15 PM Easter Daylight Time on the Orlando Sentinel website Oviedo police search for missing woman. Oviedo police continue to search for a missing elderly woman. The Oviedo Police Department said resident #1, was last seen Monday around 8:30 PM, at her assisted living facility in Oviedo. The resident, who had was described as 5 feet tall and 126 pound with white, shoulder-length hair. She was last seen wearing a dark-colored jacket and white shirt. She also walked with a cane.

The Seminole County Sheriff's event report dated indicated a call was received on at 8:35 PM to report a missing resident at 355 Alafaya Woods Blvd. Oviedo, Fl. 32765. According to the report, the resident was missing since 7:30 PM. At 8:50 PM the police went to Bonfires Restaurant because the last time she went missing (S08) she went there. At 11:26 the bloodhounds were brought in. At 1:59 AM the resident was located at the facility.

The Oviedo Police Department report dated at 8:37 PM indicated the staff present during the search (other staff came to assist). He asked if all the were searched and "I was assured every checked". The Sargent asked the staff to double check and the

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staff present stated that every every closet, behind every shower curtain, under all beds had been double checked. He repeatedly asked for the facility to be double checked. Staff E was asked to check all the again. She found the resident sleeping in which was supposed to be locked. She unlocked it and found the resident sleeping. She was well and did not need medical attention.

The facility's missing resident protocol indicated that assigned staff would conduct a The facility's elopement definition was "when a resident leaves the facility property beyond the perimeter of the parking lot or further and is missing for _blank__ hours or more, without the facility's knowledge and who have not signed out nor verbally informed the facility of their plans for returning". The procedure was to assess residents who were at risk of wandering and or eloping.

The Adverse Report Day 1 dated indicated an elopement had occurred on During routine rounds after supper, resident assistant noted resident (#1) was absent from the community. There were no notations in resident's sign out sheet to indicate she went out. Procedure for elopement was started at 7:40 PM. Internal search and search of the perimeter was started. Executive Director, Resident Care Director, resident's daughter and Oviedo police were notified.

The Adverse Report -15 day dated indicated that after a search the resident was not found. The Oviedo Police, Oviedo Fire Department, search teams, helicopter, other law enforcement agencies, and Savannah Court staff searched for the resident inside and the parameters of the facility. At 2:35 AM on the resident was found sleeping in a model her building. The resident's daughter was present, law enforcement was notified, and search was stopped. The resident was unharmed. She apparently walked into the model went to sleep in the bed. Two (2) staff members working at the facility at the time; staff A and staff B were the staff present. The analysis of the event was that apparently during an internal search, model overlooked. The corrective/proactive action was to repeat elopement drills, post on cork boards in each wellness center that were vacant. Disciplinary actions were taken on the staff that did not follow policy and procedure completely.

Personnel record review for staff A, who was hired on She attended an elopement in-service on An employee warning and discipline notice dated indicated

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"Employee failed to completely search Court I for resident noted to be missing resulting in law enforcement, family member and fire department involvement. Resident located sleeping in model . . . . Employee instructed not to voice opinion to other employees accusing a fairly new employee of not searching building thoroughly. Reminded she was in charge of the building at the time and should have overseen the search was done properly". The job description indicated the staff was to follow designated plan of action in the event of a fire or other emergencies. "This job has no supervisory responsibilities".

An interview conducted on . . . . . at approximately 3 PM with staff A revealed on the t day of the elopement she came in early at approximately 2:30 PM; did a shower and about 3 PM staff B came in. About 4:15 PM we told residents to come for dinner. She added that she seated some of the residents, and started to serve dinner. At about 4:35 PM resident #1 and 2 others were not out of their . . . . . At about 4:47 PM resident #1 said she did not feel like coming out now and about 5 PM staff A did medications. About 5:48 PM staff B checked on resident #1. She saw her in the wheelchair coming from her . At 6 PM resident #1 was at the table eating dinner. At 6:45 PM she was still eating. At 7:15 PM another resident wanted to use the . . . . The Vitas nurse came looking for the medications for the hospice residents, normally about 7: PM or so. At about 7:20 PM she started passing the 8 PM medications. At 7:30 she gave resident #3 his medications. At about 7:30 PM went to the . . . . . resident #1, the door was ajar and she called her, knocked on the . . . . . and did not see her. Staff A looked on the front patio, the A hallway, the living . . . . the back patio. Staff A asked staff B if she had seen resident #1. Staff B said she had not seen resident #1 since she was put at the table and added that resident #1 told her (staff B) she was packing and was leaving. She added that when she saw staff D outside and told him about resident #1 he stated "I hope that she did not do that again".

Approximately 6 or 7 months ago a resident's family member thought they saw resident #1 walking down Alafaya Woods Boulevard. A resident's daughter had seen resident #1 by Publix, she called staff A, who called the nurse staff D and they went to look for her. The other resident's daughter was still at Publix when they arrived to pick up resident #1. The

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resident (#1) wanted to go out to street , got her in the back seat of the car of staff D and brought her back to the facility. The staff (A) stated she informed the Executive Director and the Resident Care Director. Another time resident #1 was found at the Bonfire Restaurant in the Publix plaza.

Personnel record review for staff B indicated she was hired on and had elopement in-service on

In an interview at approximately 3:30 PM with staff B revealed she last saw resident #1 about half-hour after maybe 5:30 or 6 PM. "I went to get her before dinner and her a mess. She said that she did not belong there and someone was coming to get her. I re-assured her; she said OK and I left her alone. I went to check on other residents and got caught-up with dinner. About three quarters after dinner I realized resident #1 dinner set up was empty. I went back to get her. She was in the I got her seated and served her food. She stated that she was moving. She ate her dinner. I went over to staff A to update her on my work that I had put 3 or 4 residents to bed between 7 to 7:30 PM. Resident #1 was not at her plate (at the table). I crossed path with staff A and asked her if she had seen resident #1; staff A said no. We went to check on the resident and she was not in her I checked all the except because it was (Shown to a prospector resident) was supposed to be locked. I did not check the locked A staff from the other facility was to check the locked "She was told about the resident elopement history after the event on She was also told that the resident was found by Publix once or twice and by the academy.

In an interview with staff C on approximately 11:30 AM revealed the facility did not have a model , the resident was found in the door to her The vacant at the time of the incident.

Staff D stated on at approximately 1:00 PM that staff A said that staff B said resident #1 was going home. Staff A approached him about 7:30 to 7:45 PM at the end of his shift and told him that the resident could not be located. He added that he had never heard any comments about the resident wanting to leave. That night the resident could not be located. The resident's daughter told him that the resident was and may want to leave; to go home. That night the resident came late to dinner because she was "\packing" to leave.

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The Executive Director stated on at approximately 12 PM that she could have fired staff A, but because of the years of service and good work history, she did not. Staff B was hired 2 weeks ago. Staff A relied on staff B to check the did not check her-self as it was expected as she was the senior staff and med tech, she was responsible. Staff B did not check because she was told earlier in the day that was vacant. She did not write up staff B as she was new employee.

The Resident Care Director (RCD) stated in an interview on at approximately 2:20 PM that Staff B told her resident #1 was packing to leave. She reassured the resident that it was OK to be at the facility. She added the resident had no identification on her person at that time; not then, not now. When asked if the resident was assessed for elopement, she replied that she thought so. She wanted an opportunity to go check for the assessment. She returned about 20 minutes later and stated the resident had not been assessed for elopement.

Record review for Resident #1 revealed a health assessment report dated that listed diagnoses of of disc, muscle spinal , and She had difficulty walking. She was and had Supervision was needed with ambulation, eating, and transfers. The resident needed assistance with bathing, dressing, and toileting. A health assessment dated listed diagnoses of and type A health assessment dated listed diagnoses of and Health assessment dated listed She was , forgetful and had mild to moderate The shift report binder contained the missing resident protocol. Shift report note dated indicated resident #1 refused lunch and is OK, in her "Keep a close eye on her". The Medication Observation Record dated 2013 listed 50 mg one at bedtime (8PM) and was marked as given on The resident log notes dated at 7:40 PM indicated the resident was reported missing. She was last seen at 6:30 eating dinner. Search began at 7:40 PM, outside perimeter, "inside all buildings: and surrounding areas. The police and daughter were called. Note dated at 12 AM search continues. At 2:15 AM the Executive Director called for search of again. Resident found in model

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An in-service regarding elopement/drills was held at 2 PM. According to the signature log 18 staff attended including staff B. There was no evidence that staff A attended the in-service. The RCD stated at approximately 3 PM that staff A attended the class but came late after the sign sheet was passed around. She arrived after the meeting was almost over. The Resident Care Director met with the staff after the meeting.

The RCD stated at approximately 4 PM she did not think resident #1 was going anywhere; she just went to sleep in another An identification bracelet had been given to the resident just a few minutes ago. The staff conducted head counts at 3 PM and 7 PM.

The Executive Director stated on at approximately 4:15 PM she asked staff B to double checked all the and they found the resident in bed sleeping in The facility's doors are closed and alarmed at dusk and open at sunrise. An elopement in-service was held after the incident. The RCD conducted the resident elopement procedures during orientation and the Executive Director conducted the incident /adverse reporting training. She added that she felt resident #1 was not an elopement risk as she did not elope on

Class II

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC
Based on observations, record review and interview the facility failed to ensure 1 of 3 sampled residents (#1) who was at risk of elopement, had identification on her person at all times.

Findings:

The Seminole County Sheriff's event report dated indicated a call was received on at 8:35 PM to report a missing resident at 355 Alafaya Woods Blvd. Oviedo, Fl. 32765. Per report the resident was missing since 7:30 PM. At 8:50 PM the police went to Bonfires Restaurant as the last time she went missing ("S08") she went there. At 11:26 the bloodhounds were brought in. At 1:59 AM the resident was located at the facility.

In an interview on at approximately 3 PM staff A stated about 6 or 7 months ago a resident's family member thought they saw resident #1 walking down Alafaya Woods Boulevard. A resident's daughter had seen resident #1 by Publix, she called staff A, who called the nurse staff D and they went to look for her. The other resident's daughter was still

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at Publix when they arrived to pick up resident #1. The resident (#1) wanted to go out to the street , got her in the back seat of the car of staff D and brought her back to the facility. The staff (A) stated she informed the Executive Director and the Resident Care Director. Another time resident #1 was found the Bonfire Restaurant in the Publix plaza.

In an interview on at approximately 3:30 PM staff B stated she was told about the resident elopement history after the event on and the resident was found by Publix once or twice and by the academy.

Staff D stated on at approximately 1:00 PM that staff A said that staff B said resident #1 was going home. Staff A approached him about 7:30 to 7:45 PM at the end of his shift and told him that the resident could not be located. That night the resident could not be located; her daughter told him that the resident was and may want to leave, go home. That night the resident came late to dinner because she was "packing" to leave.

The Resident Care Director (RCD) stated in an interview on at approximately 2:20 PM that Staff B told her the resident #1 was packing to leave. She added the resident had no identification on her person at that time; not then, not now. When asked if the resident was assessed for elopement, she replied that she thought so. She wanted an opportunity to go check for the assessment. She returned about 20 minutes later and sated she resident had not been assessed for elopement.

Record review for Resident #1 revealed a health assessment report dated that listed diagnoses of of disc, muscle , spinal , She had difficulty walking. She was and had Supervision was needed with ambulation, eating, and transfers. The resident needed assistance was needed with bathing, dressing, and toileting. Shift report note dated indicated resident #1 refused lunch and is OK, in her " Keep a close eye on her".

The Resident Care Director stated at approximately 4 PM she did not think resident #1 was going anywhere; she just went to sleep in another An identification bracelet had been given to the resident just a few minutes ago.

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The Executive Director stated at the time she felt resident #1 was not an elopement risk as she did not elope on and as for the other time she went for a walk.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Savannah Court Of Oviedo I
355 Alafay Woods Blvd.
Oviedo, FL 32765

Dear Administrator:

Re: CCR #2013009308

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

Attached is the provider's copy of the State (5000-3547) 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 Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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