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	AL11966665	09/26/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Avalon's Assisted Living	1250 Willow Branch Drive Orlando, FL 32828	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

List of Tags Cited:
St - A - 0004 - 58a-5.016 Fac - Licensure - Requirements S-S= C
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= D
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D
St - A - 0167 - 58a-5.025(1) Fac - Resident Contracts S-S= D
St - A - 0190 - 58a-5.033 Fac - Administrative Enforcement S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C

0000-Initial Comments
Unannounced Complaint Inspection #2013009674 was conducted from and Avalon's Assisted Living had deficiencies at the time of the visit.

0004-Licensure - Requirements 58A-5.016 FAC
Based on observation and interview, the facility failed to obtain prior approval from the Agency Central Office before increasing the number of beds to be used by the facility.

Findings:

Review of the Assisted Living Facility license on at 11:05 AM revealed the facility was licensed for 6 beds. Tour of the facility at 11:10 AM revealed there were 7 beds.

An interview was attempted with staff #A on at 11 AM but she refused to give any information regarding the current census and the residents' needs and care.

Review of admission/discharge log on at 11:15 AM revealed resident #1 was not documented as a resident.

Resident record review conducted on at 11:25 AM revealed a Facility Health Assessment Form (1823) with diagnosis of mild insufficiency, mild atelectasis in lungs, and history of On page 1 under section physical or sensory limitations was hand written "slight hearing Under or behavioral status was hand written, "forgetful/l . Under section special precautions was hand written On page 2 was checked that the resident was independent in all activities of daily living, required a regular diet, was free from communicable not bedridden, did not have any 3 or 4 pressure sores, did not pose a danger to self or others, and did not require 24-hour nursing or care. In section D,

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the physician indicated that the individual's needs could be met in an assisted living facility, which was not a medical, nursing or facility. Page 4 indicated that the resident's medications included a 81 milligrams (mg.) daily, for lipids,10 mg. at time of sleep, an anti-depressant, 25 mg. daily, and an 50 mg. at hour of sleep as needed. In section B, the physician noted that the individual did not need help with taking medications. The physician did not indicate what type of medication assistance was needed. In section C under Additional Comments/Observations, the physician hand wrote "may use a pill box". The 1823 form was dated and signed by a physician.

Review of Advanced Notification of Representative Payment form from Social Security Administration dated revealed that resident #1 understood and agreed with the following: Need For Representative Payee. Choice of Representative payee; Social Security Administration has chosen Administrator of Facility to be representative payee. The resident's right to appeal was described. The form was signed and dated by the resident on

Review of the Orange County Sheriff Office Incident Report #13-42074 dated 2013 indicated the following: Sheriff Deputy wrote, "On Thursday, 2013 at approximately 1443 hours, I responded to 3444 Old Winter Garden Road, in reference to a subject with from another state. Upon arrival, I met with name mentioned (resident #1), who came to Orlando Florida via a bus from South Carolina. (Resident #1) did not know nor did he believe he was in Orlando, Florida. He thought he was in South Carolina near his residence. I was unable to contact a next of kin for resident #1 but I did make contact with his friend who advised (resident #1) had full blown and lived in a group home in South Carolina. While speaking with (resident #1) he would become lucid and participate in the conversation, and then suddenly, he would not know who he was talking to or what was going on. Prior to leaving South Carolina, (resident #1) cleared out his bank account and was walking around the Pines Hills area with around $1400.00 cash in his pocket. Due to (resident #1's) mental state changing so rapidly from lucid to non-lucid it was difficult to communicate and he was not most of the time. He attempted to walk off several times. Sheriff Deputy contacted the Department of Children and Families (DCF) operator who advised he would take a report and send out a case worker for an immediate response. A short time there after DCF case worker responded and attempted to locate a facility to house or take care of (resident #1) until transport back to the other state can be set up. DCF Case worker was unable to locate a facility at this time. Due to (resident #1's) mental state and due to him having no knowledge of where he was, it was apparent he was unable to take care of himself at that time. Sheriff Deputy transported (resident #1) to....Mental Health

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Center....under a

Interview conducted on at 11:40 AM with the administrator who stated that resident #1 was not a resident of the facility. There was no actual file or record for the resident. The man was an independent boarder. He resided in the first the right of the inside of the front door which had never been an assisted living facility (ALF) The administrator became his representative payee for his Social Security benefits on The administrator stated that she kept resident #1's medications secured and that she put the pills in a pill box and gave pills to him. Resident #1 had been living in the facility for the past three weeks until

Observation on at 11:45 AM of the first the right inside the front door revealed a a single bed, dresser and a closet.

Unclassified

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, record review and interview, the facility failed to provide adequate supervision to resident #1 who had was brought to another facility by the administrator, and eloped from that facility. Police were not contacted immediately, and he had not been found. The sample was 7 residents.

Findings:

The agency was informed resident #1 eloped from the facility on

Record review for resident #1 revealed a Facility Health Assessment Form (1823) with diagnosis of mild insufficiency, mild atelectasis in lungs, and history of On page 1, under section physical or sensory limitations, was hand written "slight hearing under or behavioral status was hand written, "forgetful/] under section special precautions was hand written On page 2 noted the resident was independent in all activities of daily living, was not bedridden, did not pose a danger to self or others and did not require 24-hour nursing or care. In section D, the physician indicated that the individual's needs could be met in an assisted living facility, which was not a medical, nursing or facility. Page 4 indicated that the resident's medications were 81 milligrams mg. daily, used as a 10 mg. at time of sleep for lipids, 25 mg. daily, an anti-depressant, and

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50 mg., an at hour of sleep as needed. In section B, the physician noted that the individual did not need help with taking medications. In section C, under Additional Comments/Observations, the physician hand wrote "may use a pill box". The form was dated and signed by a physician.

An interview with staff #A was attempted on at approximately 10:15 AM. This staff member worked at Avalon's Assisted Living II where resident #1 eloped. Staff #A said the administrator would answer questions regarding the elopement. Staff #A was asked to give her statement regarding the elopement of resident #1 but refused to answer questions on at approximately 10:30 AM and 10:55 AM. On at approximately 2 PM, staff #A said she already gave her statement to the State and the police, she was tired and upset, and again refused to answer questions.

In an interview with the administrator on at approximately 11 AM, she stated she had been picking resident #1 up from Avalon's Assisted Living, which is a few blocks away, and dropped him off at the facility for visitation in the morning, and brought him back Avalon's Assisted Living in the evening. She did not mention a specific time. She said she was not in the facility at the time of the elopement. The resident was alert and and had lived in the Avalon's Assisted Living for 3 weeks. Just before the elopement, resident #1 was sitting outside in the back of the facility with staff #A. When staff #A stated it was time to go back inside, he did not want to go back into the facility, would not go inside the facility, and started to walk away. She asked him to come back but he would not. The last time she saw him he was at the stop sign. She said resident #1 was not admitted to Avalon's Assisted Living because he was an independent boarder.

The administrator stated on at approximately 2 PM that resident #1 lived in an unlicensed was an independent boarder.

An interview was conducted with the administrator on at approximately 3 PM. The timeline of events related to the elopement was requested. The times were not mentioned unless noted. The timeline occurred on and was stated as follows:
Resident #1 was dropped off at approximately 11 AM at Avalon's Assisted Living II.
Resident #1 went outside the facility on the back porch with Staff #A before lunch.
Staff #A called the administrator.
Resident #1 eloped at approximately 1-2 PM.
The police were called and they arrived at facility.
The administrator arrived at facility.
The police arrived with the dogs (K-9). They attempted to get the resident #1's scent for the K-9's.
The Department of Children Services and Family Services (DCFS) Adult Protective Services

Investigator (API) arrived later.
The police and API were at the facility until approximately 9 PM.
The K-9's got resident #1's scent at Publix (approximately a mile from the facility). The administrator and the police went to Publix to look at their camera video until approximately 11 PM. The resident was not seen on their video.
She stated resident #1 left with no identification, belongings or money. He had returned to his home state in the past. He did not have family locally, and there were no family members involved in his care.

In a phone interview with the Orange County Sheriff's Office (OCSO) deputy on at approximately 2:10 PM regarding Case #1300078968, the deputy stated when staff #A was interviewed she stated on at 1:15 PM that resident #1 had been missing for about 20 minutes. Staff #A was the only caregiver to care for 6 residents. Staff #A and resident #1 were sitting on the back patio. Staff #A got up and stated it was time to go inside. Resident #1 stood up and said, I am not going anywhere. He went between the houses toward the south, and to the end of the . The first time Staff #A left, she followed the resident houses to the end of the . She came back to the facility and called the administrator 2 or 3 times. Staff #A was evasive and would not answer the deputy's questions. He asked for resident #1's information. She told him she did not have any information on him. She then stated that after she called the administrator, she got in her personal vehicle to look for resident #1, and drove to both the north and south gate. She was gone 15-20 minutes. She came back to the facility and called 911. She stated she did not have his file. She called someone on the phone and called the administrator, who stated she would fax over information. Ten minutes later, a fax was received of resident #1's out of state driver's license. Staff #A stated resident #1 had and
The administrator was on the way over to the facility. The deputy interviewed a neighbor, who lived on the street behind the facility. The neighbor told the deputy at 11:30 AM that while she was watching a game show (to estimate the time), she saw an elderly man walking quickly and being chased by a "nurse". That was an hour before the OCSO was called.

The deputy asked staff #A where resident #1's . She stated it was her first day working there. She then took the officers to a gave them a pillow for the K-9 to sniff. We later found out he lived in the Avalon's Assisted Living, a few blocks away. The administrator was asked questions. She would not answer and confirm that she was the administrator. The deputy said the administrator refused to give the deputy critical information and was evasive. The deputy said he asked her if she knew resident #1 was missing but she refused to answer.

The deputy asked the administrator if resident #1 had been placed with her through the Department of Children and Families (DCF). The administrator stated she was resident #1's guardian and that he came from a inpatient facility. The OCSO had resident #1 on at 4:15 PM

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from 3444 Winter Garden Road, according to Police Report #1300042074. At that time, the officer came in contact with resident #1 at a bus station trying to go out of state and had $1,400 cash on his person.

The OCSO Incident Report #13-78968 dated [redacted] was reviewed on [redacted] at 12:15 PM. The deputy wrote: "Scene: 13230 Early Frost Circle which is a single family residence which was an adult assisted living unit(Avalon Assisted Living II). Victim: (Resident #1), who was cared for by Administrator through placement by DCFS. (Resident #1) had [redacted] and high [redacted]. Last seen wearing a pull over shirt, tan in color, with thin red and blue strips and beige pants and wearing a camouflage cap. Assisting Units: Case 3 helicopter, K-9 [redacted] hound), Patrol units, Jam units and Gang unit assisted in area searches. Two detectives from missing persons responded. DCF Investigator responded to residence after officer had cleared the scene. Upon arrival met with reporter (staff #A). (Staff #A) stated they were on the back porch area when she asked (resident #1) to come inside. She stated that (resident #1) refused and quickly left the back yard, walked around the house to the front yard to the side walk, then southbound on the sidewalk as she followed attempting to stop him by verbal commands. She said that she had to break off following him because the other clients were left alone. (Staff #A) told me she first called the administrator and when I asked her who the administrator was, she would not answer me. She stated she left the clients in the residence and drove her car around the neighborhood and up to both gates in an attempt to locate (resident #1). She stated she returned 10 to 15 minutes later and then called the Sheriff's Office. (Staff #A) was very evasive regarding (resident #1's) information. She told me this was her first time at that residence and she only worked for the company for 2 to 3 weeks. (Staff #A) could not provide me with any medical history on (resident #1) other than his diagnosis. She was only able to provide very basic information on (resident #1). About an hour later, the administrator arrived at the scene. Upon me asking her questions she was also very evasive, even to the point that she would not confirm or deny that she knew (resident #1) was missing. I learned that (resident #1) was a day guest at this location for the day and stayed at 1250 Willow Branch (Avalon's Assisted Living). This was in direct conflict with what several of the clients were saying. They said (resident #1) had been living at Avalon's Assisted Living for two to three weeks. The K9 track and helicopter search were negative. I entered (resident #1) as a missing endangered person due to his diagnosis.

In a telephone interview with the Adult Protective Investigator (API) on [redacted] at approximately 11:23 AM, she stated the resident had not yet been located.

The facility did not assess resident #1 to determine his risk of elopement and document, and did not provide adequate supervision to resident #1 to prevent elopement and potential harm. There was no documentation to indicate the resident eloped from the facility or the physician was informed of the

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elopement.

Class II

0077-Staffing Standards - Administrators 58A-5.019(1) FAC
Based on record review and interview, the administrator who was responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents:
1. failed to ensure prior approval from AHCA Agency Central Office before increasing the number of beds to be used by the facility;
2. failed to maintain an accurate work schedule and did not maintain adequate staffing hours for the number of residents in the facility;
3. failed to ensure they maintained an up to date admission discharge log;
4. failed to ensure a contract was completed for 1 of 2 sampled residents (#1);
5. allowed an employee with a disqualifying offense to have contact with a person;
6. failed to instruct staff to provide information about residents.

Findings:

1. The administrator did not obtain prior approval from AHCA Agency Central Office before increasing the number of beds.

Review of the Assisted Living Facility (ALF) license on at 11:05 AM revealed the facility was licensed for 6 beds. Tour of the facility at 11:10 AM revealed 7 beds, and on there were 7 residents residing in the facility.

Resident #1's Facility Health Assessment Form (1823) indicated diagnosis of mild insufficiency, mild atelectasis in lungs, and history of On page 1 under section physical or sensory limitations was hand written "slight hearing Under or behavioral status was hand written, "forgetful/l Under section special precautions was hand written On page 2 was checked that the resident was independent in all activities of daily living, required a regular diet, was free from communicable not bedridden, did not have any 3 or 4 pressure sores, did not pose a danger to self or others and did not require 24-hour nursing or care. In section D, the physician indicated that the individual's needs could be met in an assisted living facility, which was not a medical, nursing or facility. Page 4 indicated that

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the resident's medications included a 81 milligrams (mg.) daily, for lipids, 10 mg. at time of sleep, an anti-depressant, 25 mg. daily, and an 50 mg. at hour of sleep as needed. In section B, the physician noted that the individual did not need help with taking his or her medications. The physician did not indicate what type of medication assistance was needed. In section C under Additional Comments/Observations, the physician hand wrote "may use a pill box". The form was dated and signed by a physician.

In an interview conducted on at 11:40 AM with the administrator, she stated that resident #1 was not a resident of the facility. There was no actual file or record for the resident. The man was an independent boarder. He resided in the first the right of the inside of the front door which had never been an ALF The administrator became his representative payee for his Social Security benefits on The administrator stated that she kept resident #1's medications secured and that she put the pills in a pill box and gave pills to him. Resident #1 had been living in the facility for the past three weeks until

2. The administrator did not maintain an accurate work schedule and did not maintain adequate staffing hours.

Observation during tour of facility on at 11:15 AM revealed that staff #A was present.

Review on 1:35 PM of the written work schedule for Avalon's Assisted Living and the written work schedule for Avalon's Assisted Living II, both dated 2013, revealed that the work schedule used by the facility did not accurately reflect the staff hours. The administrator was on both schedules to work Monday - Friday 12:00 PM-8:00 PM.

In an interview conducted on at approximately 1:55 PM with the administrator, she stated said resident #1 resided at Avalon's Assisted Living for the past three weeks. Per the staffing schedule for the week of 1-7, 2013, there were a total of 130 staff hours for 7 residents. The minimum staff hours per week for 0-5 residents is 168 hours, and 212 hours for 6-15 residents.

Review conducted on at 3:50 PM of the written work schedule for Avalon's Assisted Living dated 2013 revealed a hand written addendum to the schedule with the initials for staff #C

with 7:00 AM-5:00 PM written in black ink.

Observation on at 4 PM revealed that only one staff member was present in the home at the time of the visit.

Interview was attempted on at 4:05 PM with staff #B. She refused to give her name or any other information regarding the staffing, residents or facility. Sheriff Deputy who accompanied survey team asked staff #B for her name and she refused to give her name to the Sheriff Deputy.

In an interview on the telephone with the administrator on at 4:10 PM, she identified the staff member currently in the home as staff #B. The administrator stated further that she was not sure of the full name of the staff #C who was scheduled to be in the home at that time. She would have to look the name up. The administrator stated she did not know exactly what time the staff member left the facility and she believed she would return to the facility in approximately another 20 minutes.

3. The administrator did not ensure they maintained an up to date admission discharge log. Review of facility records conducted on at 11:15 AM of the facility admission and discharge log revealed that resident #1 was not listed as a resident.

Resident record review revealed a Facility Health Assessment Form (1823) with diagnosis of mild insufficiency, mild atelectasis in lungs, and history of On page 1 under section physical or sensory limitations it was hand written "slight hearing Under or behavioral status was hand written "forgetful/l Under section special precautions was hand written On page 2 was checked that the resident was independent in all activities of daily living, required a regular diet, was free from communicable not bedridden, did not have any 3 or 4 pressure sores, did not pose a danger to self or others and did not require 24-hour nursing or care. In section D, the physician indicated that the individual's needs could be met in an assisted living facility, which was not a medical, nursing or facility. Page 4 indicated that the resident's medications were a 81 milligrams (mg.) daily, for lipids, 10 mg. at time of sleep, for lipids, 25 mg. daily, and an 50 mg. at hour of sleep as needed. The physician did not indicate what type of medication assistance was needed. In section B, the physician noted that the individual did not need help with taking his or her medications. In section C under Additional Comments/Observations, the physician hand wrote "may use a pill box". The form was dated and signed by a physician.

In an interview conducted on at 11:40 AM with the administrator, she stated that resident #1

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was not a resident of the facility. There was no actual file or record for the resident. The man was an independent boarder. He was resided in the first ... the right of the inside of the front door which had never been an ALF ... The administrator became his representative payee for his Social Security benefits on ... The administrator stated that she kept resident #1's medications secured and that she put the pills in a pill box and gave pills to him. Resident #1 had been living in the facility for the past three weeks until

4. The administrator did not complete a contract for resident #1.

Review of facility records conducted on ... at 11:15 AM of the facility admission and discharge log revealed that resident #1 was not listed as a resident.

Resident record review revealed a Facility Health Assessment Form (1823) with diagnosis of ... mild ... insufficiency, mild atelectasis in lungs, and history of ... On page 1 under section physical or sensory limitations it was hand written "slight hearing ... Under ... or behavioral status was hand written "forgetful/l ... Under section special precautions was hand written ... On page 2 was checked that the resident was independent in all activities of daily living, required a regular diet, was free from communicable ... not bedridden, did not have any ... 3 or 4 pressure sores, did not pose a danger to self or others and did not require 24-hour nursing or ... care. In section D, the physician indicated that the individual's needs could be met in an assisted living facility, which was not a medical, nursing or facility. Page 4 indicated that the resident's medications were a ... 81 milligrams (mg.) daily, ... for ... lipids, 10 mg. at time of sleep, ... for ... lipids, 25 mg. daily, and ... an ... 50 mg. at hour of sleep as needed. The physician did not indicate what type of medication assistance was needed. In section B, the physician noted that the individual did not need help with taking his or her medications. In section C under Additional Comments/Observations, the physician hand wrote "may use a pill box". The form was dated ... and signed by a physician.

In an interview conducted on ... at 11:40 AM with the administrator, she stated that resident #1 was not a resident of the facility. There was no actual file or record for the resident. The man was an independent boarder. He resided in the first ... the right of the inside of the front door which had never been an ALF ... The administrator became his representative payee for his Social Security benefits on ... The administrator stated that she kept resident #1's medications secured and that

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she put the pills in a pill box and gave pills to him. Resident #1 had been living in the facility for the past three weeks until .

There was no documentation to review to indicate a contract was completed for resident #1.

5. The administrator allowed an employee with a disqualifying offense to have contact with a person.

Review of online AHCA Background Screening results revealed staff #D was not eligible to work. The determination date was .

The hospital record indicated that the Social Worker (SW) met with the ALF administrator and ALF staff #D to discuss the patient (resident #1). SW notified them of the patient's (resident #1's) history of exit-seeking behavior upon admission to the hospital. SW discussed patient's (resident #1's) distance from family and support. SW discussed patient ' s (resident #1's) budget per month and his potential eligibility of Veterans Administration (VA) benefits. The ALF administrator and ALF staff #D agreed to accept the patient (resident#1) and said they could assist him to become established with the Orlando VA.

6. The administrator failed to instruct staff to provide information about residents.
An interview was attempted with staff #A on at 11 AM but she refused to give any information regarding the current census and the residents' needs and care. Staff #A deferred to the administrator for any information. The administrator was not present in the facility at this time.

An interview was attempted on at 4:05 PM with staff #B. She refused to give her name or any other information regarding the staffing, residents or facility. She deferred all questions to the administrator who was not present in the facility at that time. The Sheriff Deputy who accompanied survey team asked staff #B for her name, and she refused to give her name to the Sheriff Deputy.

In a telephone interview on at 4:10 p.m., the administrator said, "staff do not have to give surveyors any information. That's their right."

Class III

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0079-Staffing Standards - Levels 58A-5.019(4) FAC
Based on staff schedule review and interview, the facility failed to maintain a written work schedule which accurately reflected the facility's 24 hour staffing pattern or the minimum staffing hours for the number of residents in the facility for a given period of time.

Findings:

Observation during tour of facility on at 11:15 AM revealed one staff, #A was present. The administrator was called by staff #A who stated the administrator was at one of the other facilities.

Review on at 01:35 AM of the written work schedule for Avalon's Assisted Living and the written work schedule for Avalon's Assisted Living II, both dated 2013, revealed that the work schedule used by the facility did not accurately reflect the staff hours. The administrator was on both schedules to work Monday - Friday 12:00 PM-8:00 PM.

In an interview conducted on at approximately 1:55 PM with the administrator , she said resident #1 resided at Avalon's Assisted Living for the past three weeks. Per the staffing schedule for the week of 1-7, 2013, there were a total of 130 staff hours for 7 residents. The minimum staff hours per week for 0-5 residents is 168 hours, and 212 hours for 6-15 residents.

Review conducted on at 3:50 PM of the written work schedule for Avalon's Assisted Living, dated 2013, revealed a hand written addendum to the schedule with the initials for staff #C for 7:00 AM-5:00 PM, written in black ink.

Observation on at 4 PM revealed only one staff member, #A, was present in the home at the time of the visit.

An interview was attempted on at 4:05 PM with staff #B. She refused to give her name or any other information regarding the staffing, residents or facility. The Sheriff Deputy who accompanied survey team asked staff #B for her name, and she refused to give her name to the Sheriff Deputy.

In a telephone interview with the administrator on at 4:10 PM, she identified the staff member currently in the home as staff #B. The administrator stated further that she was not sure of the full name of the staff #C who was scheduled to be in the home at that time. The administrator stated she did not know exactly what time staff #C left the facility and she believed staff #C would return to the

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Avalon's Assisted Living	1250 Willow Branch Drive Orlando, FL 32828	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

facility in approximately another 20 minutes.

Class III

0160-Records - Facility 58A-5.024(1) FAC
Based on record review and interview, the facility failed to maintain an up-to-date admission and discharge log listing the names of all residents.

Findings:

Review of facility records conducted on at 11:15 AM of the facility admission and discharge log revealed resident #1 was not listed as a resident.

Resident #1's Facility Health Assessment Form (1823) had diagnoses of mild insufficiency, mild atelectasis in lungs, and history of On page 1 under section physical or sensory limitations was hand written "slight hearing Under or behavioral status was hand written, "forgetful/ Under special precautions was hand written On page 2 was checked that the resident was independent in all activities of daily living , required a regular diet, was free from communicable not bedridden, did not have any 3 or 4 pressure sores, did not pose a danger to self or others and did not require 24-hour nursing or care. In section D, the physician indicated that the individual's needs could be met in an assisted living facility, which was not a medical, nursing or facility. Page 4 indicated that the resident 's medications were a 81 milligrams (mg.) daily, for lipids, 10 mg. at time of sleep, for lipids, 25 mg. daily, and an 50 mg. at hour of sleep as needed. The physician did not indicate what type of medication assistance was needed. In section B, the physician noted that the individual did not need help with taking his or her medications. In section C under Additional Comments/Observations, the physician hand wrote "may use a pill box". The form was dated and signed by a physician.

In an interview conducted on at 11:40 AM with the administrator, she stated that resident #1 was not a resident of the facility. There was no actual file or record for the resident. The man was an independent boarder. He was resided in the first the right of the inside of the front door which had never been an ALF The administrator became his representative payee for his Social Security benefits on The administrator stated that she kept resident #1's medications secured

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and that she put the pills in a pill box and gave pills to him. Resident #1 had been living in the facility for the past three weeks until .

Class III

0167-Resident Contracts 58A-5.025(1) FAC
Based on record review and interview, the facility failed to execute a contract with 1 of 2 sampled residents (#1).

Findings:

Resident #1's Facility Health Assessment Form (1823) had diagnoses of , mild insufficiency, mild atelectasis in lungs, and history of . On page 1 under section physical or sensory limitations was hand written "slight hearing . Under or behavioral status was hand written, "forgetful/l . Under special precautions was hand written . On page 2 was checked that the resident was independent in all activities of daily living , required a regular diet, was free from communicable , not bedridden, did not have any , 3 or 4 pressure sores, did not pose a danger to self or others and did not require 24-hour nursing or care. In section D, the physician indicated that the individual's needs could be met in an assisted living facility, which was not a medical, nursing or facility. Page 4 indicated that the resident 's medications were a , 81 milligrams (mg.) daily, , for lipids, 10 mg. at time of sleep, , for lipids, 25 mg. daily, and an , 50 mg. at hour of sleep as needed. The physician did not indicate what type of medication assistance was needed. In section B, the physician noted that the individual did not need help with taking his or her medications. In section C under Additional Comments/Observations, the physician hand wrote "may use a pill box". The form was dated and signed by a physician.

In an interview conducted on at 11:40 AM with the administrator, she stated that resident #1 was not a resident of the facility. There was no actual file or record for the resident. The man was an independent boarder and resided in the first the right of the inside of the front door which had never been an ALF . The administrator became his representative payee for his Social Security benefits on . The administrator stated that she kept resident #1's medications secured and that she put the pills in a pill box and gave pills to him. Resident #1 had been living in the facility for the past three weeks until .

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There was no documentation to review to indicate that a resident contract had been completed.

Class III

0190-Administrative Enforcement 58A-5.033 FAC
Based on observation and interview, the facility failed to provide access to information during the complaint inspection by refusing to answer questions about resident information for 1 of 7 sampled residents (#1).

Findings:

The Agency for Health Care Administration (AHCA) received information that resident #1 eloped from the facility.

Resident record review conducted on at 11:25 AM revealed a Facility Health Assessment Form (1823) with diagnosis of , mild insufficiency, mild atelectasis in lungs, and history of On page 1 under section physical or sensory limitations was hand written "slight hearing Under or behavioral status was hand written, "forgetful/l Under section special precautions was hand written . On page 2 was checked that the resident was independent in all activities of daily living, required a regular diet, was free from communicable not bedridden, did not have any , 3 or 4 pressure sores, did not pose a danger to self or others, and did not require 24-hour nursing or care. In section D, the physician indicated that the individual's needs could be met in an assisted living facility, which was not a medical, nursing or facility. Page 4 indicated that the resident's medications included a 81 milligrams (mg.) daily, for lipids,10 mg. at time of sleep, an anti-depressant, 25 mg. daily, and an 50 mg. at hour of sleep as needed. In section B, the physician noted that the individual did not need help with taking medications. The physician did not indicate what type of medication assistance was needed. In section C under Additional Comments/Observations, the physician hand wrote "may use a pill box". The 1823 form was dated and signed by a physician.

An interview was attempted with staff #A on at 11 AM but she refused to give any information regarding the current census and the residents' needs and care. Staff #A deferred to the administrator for any information. The administrator was not present in the facility at this time.

An interview was attempted on at 4:05 PM with staff #B. She refused to give her name or any

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other information regarding the staffing, residents or facility. She deferred all questions to the administrator who was not present in the facility at that time. The Sheriff Deputy who accompanied survey team asked staff #B for her name, and she refused to give her name to the Sheriff Deputy.

In a telephone interview on at 4:10 p.m., the administrator said, "staff do not have to give surveyors any information. That's their right."

Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06
Based on record review, the facility failed to ensure that 1 of 4 assisted living facility (ALF) staff members was eligible to work (#D).

Findings:

Review of online AHCA Background Screening results revealed staff #D was not eligible to work. The determination date was

On at 1:51 p.m., review of resident #1's hospital record from through revealed a progress note dated at 4:11 PM which read, " Social Worker, Administrator and (staff #D) of Avalon Assisted Living Facility met with patient (resident #1) to discuss discharge planning. Patient (resident #1) presented as pleasant, with euthymic mood and constricted affect. Patient (resident #1) with some in thought -process. Patient (resident #1) agreed to go to Avalon Assisted Living Facility and upon termination of interview stated to Administrator and (staff #D), 'I ' ll be looking for you come Monday'. "

The hospital record indicated that the Social Worker (SW) met with the ALF administrator and ALF staff #D to discuss the patient (resident #1). SW notified them of the patient's (resident #1's) history of exit-seeking behavior upon admission to the hospital. SW discussed patient's (resident #1's) distance from family and support. SW discussed patient ' s (resident #1's) budget per month and his potential eligibility of Veterans Administration (VA) benefits. The ALF administrator and ALF staff #D agreed to accept the patient (resident#1) and said they could assist him to become established with the Orlando VA. The Social Worker was to follow-up.

Unclassified

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Avalon's Assisted Living
1250 Willow Branch Drive
Orlando, FL 32828

Dear Administrator:

Re: Complaint Inspection - CCR # 2013009674

This letter reports the findings of a Complaint Inspection 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 (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

TDC/at
Enclosure: State Form
XG90

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