| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11967298 | 09/17/2013 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| Avalon's Assisted Living Ii | 13230 Early Frost Circle Orlando, FL 32828 | |
| SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION) | | |

**List of Tags Cited:**
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= G
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= G
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= D
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= G
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= C
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

**Specific Tag Findings:**

0000-Initial Comments
Unannounced Complaint Inspection #2013009505 was conducted from and . Avalon's Assisted Living II had deficiencies found at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on record review and interview, the facility falsified the admission Assisted Living Facility Health Assessment form (1823), and did not admit a resident who needed assistance with medications for 1 of 6 sampled residents (#6).

Findings:

Resident record review revealed a Resident Health Assessment for Assisted Living Facilities Form (1823) dated that read diagnoses of and . The resident's or behavioral status read, service requirements read, "needs assist of caregiver with all care with meds." The 1823 form indicated the resident was independent with ambulation, bathing, dressing, eating, toileting and transferring. Page 4 of the 1823 read, "Does the individual need help taking his or her medications?" and "Yes" was checked. There was a line through the check with initials ERR and "No" was also marked with an X. Needs Assistance with Self-Administration of medications" was checked "yes", with a line through the check and initials ERR. Additional comments read the "resident may use a pill box from an outside nurse." The information on the 1823 form was inconsistent regarding the resident's needs for medication.

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The administrator stated on at approximately 5 PM that the resident came to the facility from a unit on . When asked who altered the 1823 form, she stated the physician's office changed the 1823 form and initialed the form. She stated the resident was an independent boarder without a rental agreement, was not a resident, said she filled his pill boxes for him.

In a telephone interview on at approximately 2 PM with the physician's office who completed the 1823 form, the staff stated that on page 4 of the 1823 form dated the physician checked off "yes" to the question: "Does the individual need help with taking his or her medications?", indicating the resident needed help with medication. There was no other documentation regarding medications or additional comments. Page 4 of the 1823 form was faxed to the physician's office for review on at 9:32 AM.

In a telephone interview on at approximately 11:05 AM with resident #6's physician's office representative who had reviewed the altered page 4 of the 1823 form, she said the physician's office did not make the changes/alterations on the 1823 form.

Class II

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on observation, record review and interview the facility failed to discharge a resident, who was who broke out his on and eloped from the facility, out the window and was at risk of harm for 1 of 6 sampled residents (#2)

Findings:

Confidential interview on at approximately 12:05 PM revealed the interviewee had spoken to Adult Protective Services and the police and other organizations many times about problems at the Assisted Living Facility (ALF). On an elderly male (who was later identified as resident #2), was observed breaking out a facility window at approximately 3:45 PM. He exited the facility through the window, stated he was locked in his day and could not get out, was standing out in the rain, seemed to be talking to a tree, and began to do calisthenics and push-ups. During that time, no staff member came outside to get the resident. The interviewee observed the resident outside of the facility for over an hour on . On , there were helicopters out looking for another resident who escaped (who was later identified as resident #1). Resident #2 was observed taking wood panels out of the facility window at the same time the helicopters were overhead. The resident was observed kicking out a facility window, leaving out the window several times and leaving the ALF property. A

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resident had tried to get into a nearby home. When the interviewee attempted to inquire at the facility, they did not answer the door.

Record review revealed resident #2 had an 1823 form dated that indicated diagnoses of non specific, left and lung nodules. The physical or sensory limitation was The or behavioral status stated: "alert and oriented to person, he was suspicious, and labile." The special precautions was precautions. The resident was independent with ambulation, bathing, dressing, eating, toileting and transferring.

Resident #2 had a previous history of elopement from the facility as follows:
Elopement #1
Review of Orange County Sheriff's Office (OCSO) Inquiry Response report #132153177 dated revealed the call was initiated at 20:45 (8:45 p.m.):
Location: 13230 Early Frost Circle, Orlando; Entry: Twenty minutes ago an adult with early onset of further information was redacted.
20:47 (8:47 p.m.) Adult went out with plastic Target (store) bag over head.
On Scene: 20:48 (8:48 p.m.)
20:49 (8:49 p.m.) Resident #2's name mentioned. Units need to check gates, it is a gated community
20:58 (8:58 p.m.) Target bag over head, was walking at a large pace, northbound towards Crown Hill. Complainant was just a house sitter.
20:59 (8:59 p.m.) Resident #2 had only been in the home for a week. He had no places he usually frequented.
21:14 (9:14 p.m.) 40-45 minute time lapse noted.
20:18 (8:18 p.m.) With Resident #2
20:39 (8:39 p.m.) Returned in good health, was found on Crown Hill and Willow Branch. Closed.

Elopement #2
Review of OCSO Inquiry Response report #132492710 dated stated the call was initiated at 16:45 (4:45 p.m.)and revealed:
Location: 13230 Early Frost Circle, Orlando
16:51 (4:51 p.m.) Male was in front yard boxing, talking to trees and vehicles. Came outside through his
17:38 (5:38 p.m.) OCSO was on the scene.
17:14 (5:14 p.m.) Resident #2 was endangered and found on Crown Hill Boulevard/Willow Branch next intersection north of Early Frost.
18:01 (6:01 p.m.) Closed.

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Elopement #3
Review of OCSO Inquiry Response report #132532080 dated . . . stated the call was initiated at 13:13 (1:13 p.m.) and revealed:
Location: 13230 Early Frost Circle, Orlando.
While OCSO was investigating the elopement of resident #1, resident #2 kicked out their . . . . . .

16:44 (4:44 p.m.) Another resident broke out the window, which required another unit to be dispatched.
16:46 (4:46 p.m.) On scene

Elopement #4
Review of OCSO Inquiry Response report #132553927 dated . . . . . The call was initiated at 21:56 (9:56 p.m.) and revealed:
Location: 13230 Early Frost Circle, Orlando
21:57 (9:57 p.m.) Entry Redacted, administrator, entry redacted.
21:59 (9:59 p.m.) kicked in boarded up windows, not being violent at that time. Had thrown objects around floor.
22:00 (10 p.m.) Complainant not impatient.
22:01 (10:01 p.m.) Complainant advised, resident jumped out window, requested resident to go to hospital for mental evaluation, will be violent.
22:02 (10:02 p.m.) Resident sitting up in driveway, diagnosed
22:04 (10:04 p.m.) Resident #2's name mentioned, diagnosed with . . . . . and . . . . .

22:05 (10:05 p.m.) Has had issues in the past with this resident, that resulted in . . . . . .
22:08 (10:08 p.m.) On Scene.
22:31 (10:22 p.m.) (hospital) mentioned.
23:08 (11:08 p.m.) Fire Department transported, OCSO followed for assistance.

Resident #2 was observed on . . . . . at approximately:
At 10:45 AM, the resident was asleep in his . . . . . his bed. The window had been kicked out and there was no glass in the window. There was an armoire pushed up to the window to cover the hole.
At 1 PM, the resident was observed ambulating in the facility attempting to play his guitar. An interview was attempted, the resident spoke in another language, was constantly redirected to speak in English,would forget mid-sentence and then revert to his native language. The resident stated he broke his window out so that he could "escape" from the facility. The resident did not know where he was, or why he was there. He wanted to go visit his family in Hialeah.
As the afternoon went on, the resident became increasingly agitated and aggressive toward other residents and was banging on his guitar.

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In an interview with the administrator on at approximately 1:30 PM, she stated the resident broke his window in 2013 and the police were not called to the facility. The facility called the family, the family called the police and the family the resident. The resident broke the window again on while the police were at the facility investigating the resident who eloped. The administrator did not mention resident #2 had also broken out his on

In an interview with OCSO deputy at approximately 2:10 PM, he was asked about the resident kicking out his during his investigation on He stated he was not at the facility to investigate the broken window. He was investigating resident #1's elopement. He stated he heard banging while in the facility, near the kitchen. The staff went to resident #2's and it was locked. The deputy went outside and observed the plywood being kicked out of the window, and resident #2 leaving out of the window.

The facility did not discharge resident #2 when he eloped the second time on kicking out the window again and putting himself at risk of harm. There was no documentation the facility informed the family or physician or took any action to provide a safe, secure environment for the resident.

Class II

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, record review and interview, the facility failed to provide adequate supervision to:
1. Resident (#2) with a and who kicked out his 4 times and eloped from the facility each time.
2. Residents (#6) who had eloped from the facility.
3. Residents #2, #3, #4, #5 and #6, when staff left the facilty, leaving residents unsupervised while searching. The sample was 6 residents.

Findings:

Prior to entrance to the facility, the Agency for Health Care Administration was informed that resident #2 eloped from the facility on

1. Confidential interview on at approximately 12:05 PM revealed the interviewee had spoken to Adult Protective Services, the police, and other organizations many times about problems at the

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Assisted Living Facility (ALF). On , the interviewee said an elderly male, later identified as resident #2, was observed breaking out a facility window at approximately 3:45 PM. He exited the facility through the window, stated he was locked in his day and could not get out, was standing out in the rain, seemed to be talking to a tree, and began to do calisthenics and push-ups. During that time, no staff member came outside to get the resident. The interviewee observed the resident outside of the facility for over an hour on . On , there were helicopters out looking for another resident who escaped (later identified as resident #1). Resident #2 was observed kicking wood panels out of the facility window at the same time the helicopters were overhead. The resident was observed kicking out a facility window, leaving out the window several times and leaving the ALF property. An unidentified resident had tried to get into a nearby home. When the interviewee attempted to inquire at the facility, no one answered the door.

Record review revealed resident #2 had an 1823 form, dated , that read diagnoses of non specific, , left and lung nodules. The physical or sensory limitation was . The or behavioral status read, "alert and oriented to person, he was suspicious, , and labile." The special precautions read, precautions." The resident was independent with ambulation, bathing, dressing, eating, , toileting and transferring.

Resident #2 was observed on at approximately 10:45 AM. The resident was asleep in his his bed. The window had been kicked out and there was no glass in the window. There was a armoire pushed up to the window to cover the hole.
At 1 PM on , the resident was observed ambulating in the facility attempting to play his guitar. An interview was attempted. The resident spoke in another language, was constantly redirected to speak in English, would forget mid-sentence and revert to his native language. The resident stated he broke his window out so that he could escape from the facility. The resident did not know where he was, or why he was there. He wanted to go visit his family in Hialeah. As the afternoon went on, the resident became increasingly agitated and aggressive toward other residents and was banging on his guitar.

Resident #2 had a previous history of elopement from the facility as follows:
Elopement #1
Review of OCSO Inquiry Response report #132153177 dated revealed the call was initiated at 8:45 p.m. and revealed the following information:
Location: 13230 Early Frost Circle, Orlando
Entry: Twenty minutes ago an adult with early onset of , further information was redacted.
20:47 (8:47 p.m.) Adult went out with plastic Target bag over head.

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On Scene: 20:48 (8:48 p.m.)
20:49 (8:49 p.m.) Resident #2's name mentioned. Units need to check gates, it is a gated community
20:58 (8:58 p.m.) Target bag over head, was walking at a large pace, northbound towards Crown Hill. Complainant was just a house sitter.
20:59 (8:59 p.m.) Resident #2 had only been in the home for a week. He had no places he usually frequented.
21:14 (9:14 p.m.) 40-45 minute time lapse noted.
21:18 (9:18 p.m.) With Resident #2
21:39 (9:39 p.m.) Returned in good health, was found on Crown Hill and Willow Branch. Closed.

Elopement #2
Review of OCSO Inquiry Response report #132492710 dated [redacted] stated the call was initiated at 16:45 (4:45 p.m.) and revealed:
Location: 13230 Early Frost Circle, Orlando
16:51 (4:51 p.m.) Entry - Male was in front yard boxing, talking to trees and vehicles. Came outside through his [redacted]
17:14 (Resident #2) was endangered and found on Crown Hill Boulevard/Willow Branch next intersection north of Early Frost.
17:38 (5:38 p.m.) OCSO was on the scene.
18:01 Closed.

Elopement #3
Review of OCSO Inquiry Response report #132532080 dated [redacted] stated the call was initiated at 13:13 and revealed:
Location: 13230 Early Frost Circle, Orlando.
While OCSO was investigating the elopement of resident #1, resident #2 kicked out his [redacted]

16:44 (2:44 p.m.) Another resident (resident #2) broke out the window, which required another unit to be dispatched.
16:46 (2:46 p.m.) On scene

Elopement #4
Review of OCSO Inquiry Response report #132553927 dated [redacted] The call was initiated at 21:56 (9:56 p.m.) and revealed:
Location: 13230 Early Frost Circle, Orlando
21:57 (9:57 p.m.) Entry Redacted, administrator, entry redacted.
21:59 (9:59 p.m.) kicked in boarded up windows, not being violent at that time. Had thrown objects

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around floor.
22:00 (10 p.m.) Complainant not impatient.
22:01 (10:01 p.m.) Complainant advised, resident jumped out window, requested resident to go to hospital for mental evaluation, will be violent.
22:02 (10:02 p.m.) Resident sitting up in driveway, diagnosed
22:04 (10:04 p.m.) Resident #2's name mentioned, diagnosed with and
22:05 (10:05 p.m.) Has had issues in the past with this resident, that resulted in
22:08 (10:08 p.m.) On Scene.
22:31 (10:31 p.m.) Florida South (hospital) mentioned.
23:08 (11:08 p.m.) Fire Department transported, OCSO followed for assistance.

In an interview with administrator on at approximately 1:30 PM, she stated the resident broke his window in 2013 and the police were not called to the facility. The facility called the family, the family called the police, and the family the resident. She did not want the resident at that time. The resident broke the window again on , while the police were at the facility investigating resident #1's elopement. The administrator did not mention resident #2 had also broken out his on .

In an interview with OCSO deputy at approximately 2:10 PM, he was asked about the resident kicking out his on . He stated, he was not at the facility to investigate the broken window but was investigating resident #1's elopement. He stated he heard banging while in the facility, near the kitchen. Staff #A went to resident #2's and it was locked. The deputy went outside and observed the plywood being kicked out of the window, and resident #2 leaving out of the window.

Record review revealed there were no notes regarding resident #2's destructive behavior or elopements out of the window or documentation that indicated the family and physician were notified.

2. Review of OCSO Inquiry Response Report #132473681 dated revealed the following information concerning resident #6:
19:57:05 (7:57:05 p.m.) Resident #6 ran out from the facility about 8 minutes ago. The resident had mental issues and hallucinations.
19:50:03 (7:50:03 p.m.) The complainant was looking for the subject.
20:01:05 (8::01:05 p.m.) The complainant advised other staff found subject.
20:01:23 (8:01:23 p.m.) The subject was okay and there were no injuries.
20:03:27 (8:03:27 p.m.) The subject and other staff were getting ready to walk back to the building.

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20:03:58 (8:03:58 p.m.) The call was completed.

Resident record review revealed resident #6 had an Assisted Living Facility Health Assessment Form (1823) dated [redacted] that indicated diagnoses of [redacted] and [redacted] The resident's [redacted] or behavioral status read, [redacted] service requirements read, "needs assist of caregiver with all care with meds." The 1823 form indicated the resident was independent with ambulation, bathing, dressing, eating, [redacted] toileting and transferring.

Observations of resident #6 on [redacted] at approximately 11:30 AM revealed the resident was ambulating in the facility and was constantly talking and obsessing over his bodily functions. On [redacted] at approximately 1:10 PM, he ambulated in the facility and was [redacted] talking about resident #1.

The administrator stated on [redacted] at approximately 2 PM that resident #1 lived in an unlicensed [redacted] was an independent/boarder without a rental agreement. The administrator did not state to the surveyors that resident #6 had eloped from the facility on [redacted]

Review of the Facility "Elopement Protocol" read:
"Elopement refers to exit-seeking behavior demonstrated by residents who are typically [redacted] These residents are constantly looking for a way out of the building. They may be searching for a specific place. Although it is common that a [redacted] individual may not know what or who they are searching for and are just 'searching'. The facility shall implement the following procedures in prevention and intervention of a elopement. Any resident diagnosed with a memory/ [redacted] will not leave building without an escort. Should an elopement occur, an immediate systematic search of property and surrounding neighborhood will take place. If resident is not found within fifteen minutes, law enforcement will be notified. One staff member is assigned to remain at the facility, manning telephone as communications point. Re-evaluate if resident is appropriate to be retained in the facility. A complete investigation will be done of the elopement. Specific checks of alarms, doors and staff intervention will be noted. Plan of correction and future intervention will be addressed. Elopement Training Program: Interventions - You may have to utilize one-on-one supervision in difficult cases or assign a staff member per shift to be responsible for the resident's whereabouts on the shift. Documentation - For each admission, the admission coordinator should ask about elopement behavior and document the response in the resident record. Monitor documentation in communication logs and staff meetings regarding resident behaviors. Keep an elopement book with details about each resident at risk of elopement. If elopement does occur, do reporting to AHCA. Don't forget to do interviews with all staff involved and document the interview."

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SUMMARY STATEMENT OF DEFICIENCIES
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The facility failed to implement and follow their "Elopement Protocol" when residents #1, #2 and #6, each diagnosed eloped from the facility. The residents in the facility when these resident eloped,were left unattended. residents left the building without an escort. Law enforcement was not notified immediately for resident #1. Resident #1 was not assessed for his risk of elopement risk upon admission. Resident #2, after multiple elopements, was not re-evaluated for continued appropriateness of placement. Staff supervision was not increased. There was no documentation of elopements or interventions to be implemented for any residents.

3. Residents #2, #3, #4, #5 and #6 were left alone in the facility while Staff #A was outside on the back porch with resident #1, and also when she left the facility to search for resident #1 twice on foot and in her car, when the resident left the building. The residents had medical and issues that required supervision and knowledge of their whereabouts at all times.

Review of the 1823 forms for residents #3, #4 and #5, who were left unattended, revealed the following information:
Resident #3 had an 1823 form, dated , that stated diagnoses of and The resident was independent with ambulation, transferring and eating and needed assistance with bathing, dressing, and toileting.

Observation on at approximately 10:30 AM found resident #3 watching television and ambulating in the facility observed throughout the day.

Resident #4 had an 1823 form,dated , that stated diagnoses of aneurysm, large basilar aneurysm, with an ejection fraction of 25% (ejection fraction is a measurement of the percentage of leaving your each time it contracts), and The resident needed assistance with ambulation, bathing, dressing, eating, toileting and transferring.

Observation on at approximately 10:45 AM found resident #4 ambulating in the facility. The resident was very frail, unstable in gait and needed assistance ambulating, transferring and toileting. On at approximately 12:05 PM, the resident was found sleeping in his

Resident record review revealed resident #5 had an 1823 form, dated , that indicated diagnoses of aggressive behavior, rule out rule out rule out behavioral disturbances and . The resident was independent with ambulation, needed assist with bathing, dressing, eating, and supervision toileting and transferring was blank.

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Observation on at approximately 3 PM found resident #5 exit seeking at the front door. Staff #A continuously redirected him. On at approximately 4:30 PM, he approached Staff #A cooking at the stove and attempted to grab meat from the hot frying pan. The administrator redirected him to his where he was observed in the doorway, grabbing the administrator by the arm and shoving her. She redirected him to lie down until dinner was ready.

In an interview with the administrator on at approximately 2 PM, she stated no other residents eloped from the facility before resident #1 eloped on

Staff #A left the residents unattended in the facility when she went out on the back porch with resident #1 and when she left the facility property and walked up the road, houses, to search for the resident #1. Staff #A returned to the facility, then got into her vehicle to continue searching for resident #1 and left the residents unsupervised and at risk of injury or approximately 15-20 minutes.

Class II

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation and interview the facility failed to provide a decent living environment for 1 of 6 sampled residents (#2), did not repair his broken and failed to treat residents with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy by locking the residents out of their (#2 & 6).

Findings:

1. Observation on at approximately 1:15 PM revealed the window in resident #2's broken out and it was open. The metal frame that held the window glass was bent. An armoire was placed in front of the window.

Record review revealed resident #2 had an 1823 form, dated that stated diagnoses of non-specific, left and lung nodules. The physical or sensory limitations stated: The or behavioral status read: "alert and oriented to person, he was suspicious, and labile." The special precautions were precautions".

In an interview with administrator on at approximately 1:30 PM, she stated the resident broke the window previously in 2013 and repaired the window with Plexiglas. The resident broke the window again on while the police were at the facility investigating the elopement of resident #1.

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| **Avalon's Assisted Living II** | **13230 Early Frost Circle Orlando, FL 32828** | |
| SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION) | | |

Review of Orange County Sheriff's Office (OCSO) Inquiry Response report #132153177 dated read:
Location: 13230 Early Frost Circle, Orlando
20:47 (8:47 p.m.) Adult went out with plastic Target bag over head.

Review of Orange County Sheriff's Office (OCSO) Inquiry Response report #132492710 dated read:
Location: 13230 Early Frost Circle, Orlando
16:51 (2:51 p.m.) Entry - Male was in front yard boxing, talking to trees and vehicles. Came outside through his

Review of Orange County Sheriff's Office (OCSO) Inquiry Response report #132532080 dated read:
Location: 13230 Early Frost Circle, Orlando.
16:44 (2:44 p.m.) Another resident broke out the window, which required another unit to be dispatched.

The administrator was observed attempting to repair the window and place plywood in the window on at approximately 1:45 PM. She stated the window parts were on order. The administrator attached the plywood on the inside and outside of the window frame on at approximately 4 PM. The administrator did not mention that the window had previously been kicked out on

Observation on at approximately 2:30 PM revealed the exterior window covered with plywood. It was unknown how long the window was repaired with plywood, as review of the Police Inquiry reports stated the window was broken out on

2. Observation of resident #6 on at approximately 1:49 PM revealed he asked Staff #A why his door was locked and she unlocked it for him.

Observations during the complaint survey conducted on revealed that all resident and any other doors to the outside of the facility were locked at all times by staff #A. Any time a resident wanted to go into his/her , the resident had to ask staff #A to unlock the door for him/her. Resident were not observed to possess a key.

Interview conducted on at 2:00 PM with staff #A who stated she had already given her statement to the State and Police, was tired and upset, and refused to answer any questions.

Class III

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11967298 | 09/17/2013 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| Avalon's Assisted Living Ii | 13230 Early Frost Circle Orlando, FL 32828 | |
| SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION) | | |

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC
Based on observation, record review and interview, the facility failed to ensure a resident identified as at risk of elopement had identification (ID) on their person that included their name, the facility's name, address and telephone number for 1 of 6 sampled residents (#2).

Findings:

Record review for resident #2 revealed an assisted living facility (ALF) 1823 form dated _____ with diagnoses of status post right _____ repair, _____ _____, and _____. It also indicated he wandered and was an elopement risk.

Review of Orange County Sheriff's Office (OCSO) Inquiry Response Reports for resident #2 were as follows:
#13215377 dated _____ revealed that a call was placed at 20:45 (8:45 PM) stating that resident #2 went out through his _____ _____ in Assisted Living Facility located at 13230 Early Frost Circle, Orlando, Florida, 32828. Resident #2 had plastic Target (store) bag over head. Sheriff department conducted search of community. At 20:58 (8:58 PM) resident #2 with plastic Target (store) bag over head, was walking at large. At 21:14 (9:14 PM) 40-45 minute time lapse now. At 21:18 (9:18 PM) with resident #2 now. Resident #2 returned to the facility at 21:39 (9:39 PM) unharmed.

#132492710 dated _____ at 16:51 (4:51 PM), Sheriff Deputy responded to 13230 Early Frost Circle, Orlando, Florida, 32828. Report stated resident #2 talking to trees and vehicles. Came outside through _____ _____. Resident had history of making false statement regarding hostage situation. Resident #2 found at Crown Hill Boulevard and Willow Branch Road. Returned to facility safe at 17:14 (5:14 PM). Case closed at 17:43 (5:43 PM).

#132532080 dated _____ at 16:44 (4:44 PM) while investigation missing person report on resident #1 at Adult Living Facility located at 13230 Early Frost Circle, Orlando, Florida, 32828 , Sheriff Deputy observed Resident #2 kicking the plywood out from his _____ _____ and climbing out the window.

#132553927 dated _____ at 21:56 (9:56 PM) Sheriff Deputy responded to report at 13230 Early Frost Circle, Orlando, Florida, 32828 that resident #2 had kicked out boarded up window. 21:59 (9:59 PM) Throwing objects around the floor. 22:00 (10:00 PM) Complainant is not _____ inpatient, requesting resident #2 be taken to hospital for mental evaluation. 22:02 (10:02 PM) Resident #2 sitting up in driveway. 23:08 (11:08 PM) Resident #2 transported by fire department to (hospital) for a

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mental evaluation. Sheriff Deputy followed for assistance.

Observation on at approximately 2 PM revealed the resident did not have ID on his person that stated his name, the facility's name, address and telephone number.

In an interview with the staff #A on at approximately 2:05 PM, she stated the resident had an ID bracelet. She did not know where it was now and why he was not wearing it. In an interview with the manager on at approximately 4:15 PM, he had no comment.

Class III

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, failed to ensure:
The admission 1823 form was not falsified for 1 of 6 sampled residents (#6);
An inappropriate resident, with a history of multiple elopements, was retained for 1 of 6 sampled residents (#2);
Adequate supervision was provided to 2 of 6 sampled residents (#2 & 6) who eloped from the facility, and to 5 of 6 sampled residents (#2, 3, 4, 5 & 6) with medical and concerns during resident #1's elopement, when staff left residents alone in the facility during her search;
A resident was provided a decent living environment for 1 of 6 sampled resident (#2), and residents were not locked out of their
A resident with a history of multiple elopements, had identification on their person at all times for 1 of 6 sampled residents (#2);
An accurate written work schedule was maintained;
Structural systems and appurtenances were maintained in good working order;
An up-to-date admission and discharge log was maintained;
Demographic information was available for 1 of 6 sampled residents (#6);
Adverse incident reports were completed for 2 of 6 sampled residents (#2 & 6); and
A contract was completed for 1 of 6 sampled residents (#6).

Findings:

1. The facility falsified the admission 1823 form for resident #6.

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Record review for resident #6 revealed a Resident Health Assessment for Assisted Living Facilities Form (1823), dated stated diagnoses of and The resident's or behavioral status read, service requirements read, "needs assist of caregiver with all care with meds." The 1823 form read the resident was independent with ambulation, bathing, dressing, eating, toileting and transferring. Page 4 of the 1823 form read, "Does the individual need help taking his or her medications?" "Yes" was checked. There was a line through the check with initials BRR. "No" was also marked with an "X". "Needs Assistance with Self-Administration of medications" was checked "yes", with a line through the check and initials ERR. Additional comments read, the "resident may use a pill box from an outside nurse." The information on the 1823 form was inconsistent regarding the resident's needs for medication.

The administrator stated on at approximately 5 PM that the resident came to the facility from a unit on When asked who altered the 1823 form, she stated the physician's office changed the 1823 form and initialed the form. She stated the resident was an independent boarder without a rental agreement, was not a resident, and said she filled his pill boxes for him.

A telephone interview was conducted on at approximately 11:05 AM with a representative from resident #6's physician office. The representative was asked who had altered page 4 of the Form 1823. Th representative replied that the physician's office did not make the changes/alterations on the 1823 form.

2. The facility retained resident #2, an inappropriate resident with a history of multiple elopements. The Agency for Health care Administration (AHCA) received information that resident #2 had multiple elopements from the facility.

In an attempted interview with staff #A on at approximately 10:15 AM, she told the surveyor to wait for the administrator who was outside of the facility, to come in and answer questions regarding the elopement. Staff #A was asked to answer questions on at approximately 10:30 AM and at 10:55 AM. On at approximately 2 PM, staff #A again refused to answer questions.

Record review revealed resident #2 had an 1823 form, dated that indicated diagnoses of non specific, left and lung nodules. The physical or sensory limitation was The or behavioral status was "alert and oriented to person....suspicious, and labile." The special precaution was precautions". The resident was independent with ambulation, bathing, dressing, eating, toileting and transferring.

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

Review of the 2013 Work Schedule revealed staff #A worked on from 8 AM to 8 PM when resident #2 eloped from the facility at 4:45 p.m. Staff #A also worked on from 8 a.m. to at 8 a. m., when resident #2 eloped from the facility again at 4:46 p.m. However, staff #A refused to answer any questions and deferred all questions to the administrator regarding the elopements and any other questions asked of her.

Review of Police Inquiry Response Reports for resident #2 revealed the following information: Police Inquiry Response Report #13215377, dated revealed that a call was placed at 8:45 p.m. stating that resident #2 went out through his in Assisted Living Facility located at 13230 Early Frost Circle, Orlando, Florida, 32828. Resident #2 had plastic Target bag over head. The Sheriff's department conducted a search of community. At 8:58 p.m., resident #2 had a plastic Target (store) bag over head, was walking at large. At 9:14 p.m., 40-45 minute time lapse now. At 9:18 p.m. with resident #2 now. Resident #2 returned to the facility at 9:39 p.m. unharmed.

Police Inquiry Response Report #132492710, dated at 4:51 p.m., the Deputy responded to 13230 Early Frost Circle, Orlando, Florida, 32828. The report stated that resident #2 "was talking to trees and vehicles. Came outside through (Resident) had history of making false statement regarding hostage situation. (Resident # 2) found at Crown Hill Boulevard and Willow Branch Road. Returned to facility safe at 17:14 (5:14 p.m.). Case closed at 17:43 (5:43 p.m.)."

Police Inquiry Response Report #132532080, dated at 16:44 (2:44 p.m.) while investigation missing person report on (resident #1) at Adult Living Facility located at 13230 Early Frost Circle, Orlando, Florida, 32828, Sheriff Deputy observed (resident #2) kicking the plywood out from his and climbing out the window.

Police Inquiry Response Report #132553927, dated at 21:56 7:56 p.m.) Sheriff Deputy responded to report at 13230 Early Frost Circle, Orlando, Florida, 32828 that (resident #2) had kicked out boarded up window. 21:59 (9:59 p.m.) Throwing objects around the floor. 22:00 (10 p.m.) Complainant is not inpatient requesting (resident #2) be taken to hospital for mental evaluation. 22:02 (10:02 p.m.) (resident #2) sitting up in driveway. 23:08 (11:08 p.m.) (resident #2) transported by fire department to....Hospital for a mental evaluation. Sheriff Deputy followed for assistance."

The resident was retained in the facility until his fourth elopement on when he was

3. The facility did not provide adequate supervision to 2 of 6 sampled residents (#2 & 6) who eloped

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from the facility, and to 5 of 6 sampled residents (#2, 3, 4, 5 & 6) with medical and issues, during resident #1's elopement, when staff left residents alone in the facility during her search.

Record review revealed resident #2 eloped from the facility on during the elopement of resident #1 and on , and was on .

Review of Orange County Sheriff's Office (OCSO) Inquiry Response Report #132473681 dated at:
19:57 (7:57 p.m.) Resident #6 ran out from the facility about 8 minutes ago. The resident had mental issues and hallucinations.
19:50 (7:50 p.m.) The complainant was looking for the subject.
20:01 (8:01 p.m.) The complainant advised other staff found subject.
20:01 The subject was okay and there were no injuries.
20:03 (8:03 p.m.) The subject and other staff were getting ready to walk back to the building.
20:03 The call was completed.

Resident record review revealed resident #6 had an Assisted Living Facility Health Assessment Form 1823, dated that stated diagnoses of and . The resident's or behavioral status stated, service requirements stated, "needs assist of caregiver with all care with meds." The 1823 form indicated the resident was independent with ambulation, bathing, dressing, eating, toileting and transferring.

Residents #2, #3, #4, #5 and #6 were left alone in the facility while staff #A was outside on the back porch with resident #1, and when she left the facility to search for resident #1 twice on foot and in her car. The residents had medical and needs that required supervision and knowledge of their whereabouts at all times.

Review of the 1823 forms for resident #3, #4 and #5, who were left unattended revealed:
Resident #3 had an 1823, dated that stated diagnoses of and . The resident was independent with ambulation, transferring and eating and needed assistance with bathing, dressing, and toileting.

Resident #4 had an 1823 form, dated that indicated diagnoses of aneurysm, large basilar aneurysm, with ejection fraction of 25%, and . The resident needed assistance with ambulation, bathing, dressing, eating, toileting and transferring.

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Resident record review revealed resident #5 had an 1823 form, dated that stated diagnoses of , aggressive behavior, rule out , rule out rule out behavioral disturbances and . The resident was independent with ambulation, needed assist with bathing, dressing, eating, and supervision toileting and transferring was blank.

4. Resident #2 was not provided a decent living environment, and residents were locked out of their

Observation on at approximately 1:15 PM revealed the window in resident #2's broken out and it was open. The metal frame that held the window glass was bent. There was an armoire placed in front of the window.

In an interview with the administrator on at approximately 1:30 PM, she stated the resident broke the window out previously in 2013 and she repaired the window with Plexiglas. The resident broke the window again on while the police were here investigating the elopement of resident #1.

Review of OCSO Inquiry Response reports revealed the following information:
Sheriff's Office Inquiry Response #132153177 dated read:
"Location: 13230 Early Frost Circle, Orlando
20:47 (8:47 p.m.) Adult went out with plastic Target (store) bag over head."
Sheriff's Office Inquiry Response #132492710 dated read,
"Location: 13230 Early Frost Circle, Orlando
16:51 (2:51 p.m.) Entry - Male was in front yard boxing, talking to trees and vehicles. Came outside through his
Sheriff's Office Inquiry Response #132532080 dated read,
"Location: 13230 Early Frost Circle, Orlando.
16:44 (2:44 p.m.) Another resident (#2) broke out the window, which required another unit to be dispatched."

The administrator was observed attempting to repair the window and place plywood in the window on at approximately 1:45 PM. She stated the window parts were on order. The administrator attached the plywood on the inside and outside of the window frame on at approximately 4 PM. The administrator did not mention the window had previously been kicked out on

Observation of resident #6 on at approximately 1:49 PM revealed he asked staff #A why his door was locked and she unlocked it for him.

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Observations during the complaint inspection conducted on revealed that all resident and any other doors to the outside of the facility were locked at all times by staff #A. Anytime a resident wanted to go into their they had to ask staff #A to unlock the door for them. No resident was observed to possess a key.

5. Resident #2 had a history of multiple elopements but did not have identification on their person at all times.

Record review revealed resident #2 eloped from the facility on and

Observation of resident #2 on at approximately 3 PM revealed the resident was not wearing any type of identification with his name the facility's name, address or telephone number on it.

6. The facility did not maintain an accurate written work schedule.

Review on at 1:35 PM of the written work schedule for Avalon's Assisted Living II and the written work schedule for Avalon's Assisted Living 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.

7. The facility did not maintain structural systems and appurtenances in good working order.

Observation on at approximately 1:15 PM revealed the window in resident #2's broken out and it was open. The metal frame that held the window glass was bent. There was an armoire placed in front of the window.

Observation on at approximately 2:30 PM revealed the exterior window was covered with plywood.

Record review revealed resident #2 eloped from the facility on and at 9:59 p.m. through his

In an interview with the administrator on at approximately 1:30 PM, she stated the resident broke the window out previously in 2013 and it was repaired with Plexiglas. The resident broke the window again on , while the police were here investigating the elopement of resident #1.

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The administrator was observed attempting to repair the window and place plywood in the window on at approximately 1:45 PM. She stated the window parts were on order. The administrator attached the plywood on the inside and outside of the window frame on at approximately 4 PM. The administrator did not mention the window was previously kicked out on

8. An up-to-date admission and discharge log was maintained.

Record review for resident #6 revealed an Assisted Living Facility Health Assessment Form 1823, dated , that stated the resident needed assistance with medication.
The resident required assistance with self-administration of medication, was an Assisted Living Facility resident, that required the resident to be listed on the Admission/discharge log.

9. Demographic information was not completed for residents #6.

Record review for resident #6 revealed an Assisted Living Facility Health Assessment Form 1823, dated , that stated the resident needed assistance with medication.
The resident required assistance with self-administration of medication, was an Assisted Living Facility resident, that required the resident's demographic information to be documented and available.

10. Adverse incident reports were no completed for residents #2 and # 6.

Record review revealed resident #2 eloped from the facility on and and resident #6 eloped from the facility on

Review of Agency for Healthcare Administration website to access adverse incident reports on did not reveal any incident reports submitted for residents #2 or #6.

11. Resident #6, an Assisted Living Facility resident, did not have a resident contract completed.

Record review for resident #6 revealed an Assisted Living Facility Health Assessment Form 1823, dated , indicated the resident needed assistance with medication. The resident required assistance with self-administration of medication, which required a resident contract to be completed.

Class II

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
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0079-Staffing Standards - Levels 58A-5.019(4) FAC
Based on record review and interview, the facility failed to maintain a written work schedule which accurately reflected the facility's 24 hour staffing pattern.

Findings:

Review on [redacted] at 1:35 PM of the written work schedule for Avalon's Assisted Living II and the written work schedule for Avalon's Assisted Living both dated [redacted] 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 [redacted] at 2 PM with direct care staff member #A, she stated she already given her statement to the State and Police and was tired and upset and refused to answer any questions.

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC
Based on observation and interview, the facility failed to provide an environment that structural systems and appurtenances were maintained in good working order.

Findings:

Observation on [redacted] at approximately 1:15 PM revealed the window in resident #2's [redacted] broken out and it was open. The metal frame that held the window glass was bent. There was an armoire placed in front of the window.

In an interview with administrator on [redacted] at approximately 1:30 PM, she said the resident broke the window out previously in [redacted] 2013 and was repaired with Plexiglas. The resident broke the window again on [redacted] while the police were here investigating the elopement of resident #1.

Review of Orange County Sheriff's Office (OCSO) Inquiry Response reports revealed:
#132153177 dated [redacted] read, "Location: 13230 Early Frost Circle, Orlando; 20:47 (8:47 p.m.) Adult went out [redacted] with plastic Target (store) bag over head."

#132492710 dated [redacted] read, "Location: 13230 Early Frost Circle, Orlando; 16:51 (4:51 p.m.) - Male was in front yard boxing, talking to trees and vehicles. Came outside through his

window."

#132532080 dated read, "Location: 13230 Early Frost Circle, Orlando. 16:44 (4:44 p.m.) Another resident broke out the window, which required another unit to be dispatched."

#132553927 dated The call was initiated at 21:56 and read, "Location: 13230 Early Frost Circle, Orlando; 21:59 (7:59 p.m.) (Resident #2) kicked in boarded up windows."

The administrator was observed attempting to repair the window and place plywood in the window on at approximately 1:45 PM. She stated the window parts were on order. The administrator attached the plywood on the inside and outside of the window frame on at approximately 4 PM. The administrator did not mention the window was previously kicked out on

Observation on at approximately 2:30 PM revealed the exterior window covered with plywood. The window's structural system and the supporting appurtenances were not maintained in good working order.

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, and did not include 1 of 6 sampled residents (#6).

Findings:

Review of facility records conducted on at 1:15 PM of the facility admission and discharge log did not reveal resident #6 listed on the admission/discharge log as a resident.

In an interview conducted on at 2:40 PM with the administrator, she stated that resident #6 was not a resident of the facility. There was no actual file or record for the resident. She said , the "man was an independent boarder." He resided in the first the left as you entered the front door, which has never been an assisted living facility (ALF) The administrator stated that she kept resident #6's medications secured in the garage and that she put the pills in a pill box and gave the pill box to him in the morning and evening.

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Record review for resident #6's Assisted Living Facility Health Assessment Form (1823) form dated indicated diagnoses of and The resident's or behavioral status read, service requirements read, "needs assist of caregiver with all care with meds." The 1823 form indicated the resident was independent with ambulation, bathing, dressing, eating, toileting and transferring. Page 4 of the 1823 read, "Does the individual need help taking his or her medications?" "Yes" was checked.

In a telephone interview on at approximately 2 PM with an office representative of the physician, who completed the 1823, the office representative said, "on page 4 of the 1823 dated on the physician checked off yes. The resident needed help with medication."

The resident required assistance with self-administration of medications, which required the resident to be listed on the admission/discharge log.

Class III

0162-Records - Resident 58A-5.024(3) FAC
Based on observation, record review and interview the facility failed ensure demographic information was available for 1 of 6 sampled resident (#6).

Findings:

The administrator stated on at approximately 5 PM that resident #6 was admitted to the facility from a unit on The administrator stated the resident was an independent boarder without a rental agreement, was not a resident, and said she filled his pill boxes for him.

Review of the admission/discharge log revealed the resident was not documented on the log. The administrator was asked to provide all information/documentation on resident #6. An Assisted Living Facility Health Assessment Form (1823) was provided for resident #6 but the demographic information was not provided.

Resident #6's record revealed an Assisted Living Facility Health Assessment Form (1823) dated that indicated diagnoses of and The resident's or behavioral status was service

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requirements indicated, "needs assist of caregiver with all care with meds." The 1823 form indicated the resident was independent with ambulation, bathing, dressing, eating, toileting and transferring. Page 4 of the 1823 form read, "Does the individual need help taking his or her medications?" "Yes" was checked. There was a line through the check with the initials BRR. "No" was also marked with an "X". "Needs Assistance with Self-Administration of medications" was checked "yes" with a line through the check and the initials ERR. Additional comments read, the "resident may use a pill box from an outside nurse." The information on the 1823 form was inconsistent regarding the resident's needs for medication.

In a telephone interview on at approximately 2 PM with an office representative of the physician, who completed the 1823, she stated that on page 4 of the 1823 form dated on the physician checked off "yes", the resident needed help with medication. On page 4 of the 1823 form was written "received by fax on ' at approximately 2:30 PM. Page 4 of the 1823 read, "Does the individual need help with taking his or her medications?" "Yes" was checked.

The resident was in need of assistance with medications and required the demographic information to be completed.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on record review and interview, the facility failed to submit Adverse Incident reports for events reported to law enforcement for investigation of 5 elopement events for 2 of 6 residents (#2 & 6).

Findings:

1. Record review revealed resident #2 had an 1823 form dated that indicated diagnoses of non specific, left and lung nodules. The physical or sensory limitation was The or behavioral status read, "alert and oriented to person, he was suspicious, and labile." The special precautions read, precautions." The resident was independent with ambulation, bathing, dressing, eating, toileting and transferring.

Review of Orange County Sheriff's Office (OCSO) Inquiry Response Reports for resident #2 were: #13215377 dated revealed that a call was placed at 20:45 stating that resident #2 went out through his in Assisted Living Facility located at 13230 Early Frost Circle, Orlando,

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11967298 | 09/17/2013 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| Avalon's Assisted Living Ii | 13230 Early Frost Circle Orlando, FL 32828 | |
| SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION) | | |

Florida, 32828. Resident #2 had plastic Target (store) bag over head. Sheriff department conducted search of community. At 20:58 (8:58 p.m.) resident #2 with plastic Target (store) bag over head, was walking at large. At 21:14 (9:14 p.m.) 40-45 minute time lapse now. At 21:18 (9:18 p.m.) with resident #2 now. Resident #2 returned to the facility at 21:39 (9:39 p.m.) unharmed.

#132492710 dated [redacted] at 16:51 (4:51 p.m.), Sheriff Deputy responded to 13230 Early Frost Circle, Orlando, Florida, 32828. Report stated that resident #2 talking to trees and vehicles. Came outside through [redacted] Resident had history of making false statement regarding hostage situation. Resident #2 found at Crown Hill Boulevard and Willow Branch Road. Returned to facility safe at 17:14 (5:14 p.m.). Case closed at 17:43 (5:43 p.m.).

#132532080 dated [redacted] at 16:44 (4:44 p.m.) while investigation missing person report on resident #1 at Adult Living Facility located at 13230 Early Frost Circle, Orlando, Florida, 32828, Sheriff Deputy observed resident #2 kicking the plywood out from his [redacted] and climbing out the window.

#132553927 dated [redacted] at 21:56 (9:56 p.m.) Sheriff Deputy responded to report at 13230 Early Frost Circle, Orlando, Florida, 32828 that resident #2 had kicked out boarded up window. 21:59 (9:59 p.m.) Throwing objects around the floor. 22:00 (10 p.m.) Complainant is not [redacted] inpatient requesting resident #2 be taken to hospital for mental evaluation. 22:02 (10:22 p.m.) Resident #2 sitting up in driveway. 23:08 (11:08 p.m.) Resident #2 transported by fire department to (the hospital) for a mental evaluation. Sheriff Deputy followed for assistance.

Record review revealed resident #2 had an 1823 form dated [redacted] that indicated diagnoses of [redacted] non specific, [redacted] left [redacted] and lung nodules. The physical or sensory limitations stated: [redacted] The [redacted] or behavioral status read, "alert and oriented to person, he was suspicious, [redacted] and labile." The special precaution was [redacted] precautions. The resident was independent with ambulation, bathing, dressing, eating, [redacted] toileting and transferring.

There was no documentation to review to indicate the facility complete an adverse incident report for each of resident #2's elopements.

2. Review of resident #6's Assisted Living Facility Health Assessment Form (1823) dated [redacted] indicated diagnoses of [redacted] and [redacted] The resident's [redacted] or behavioral status stated, [redacted] service requirements read, "needs assist of caregiver with all care with meds." The 1823 form indicated the resident was independent with ambulation, bathing, dressing, eating, [redacted] toileting and transferring.

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Review of OCSO Inquiry Response Report #132473681 dated . . . . . revealed the following information:
19:57 (7:57 p.m.) Resident #6 ran out from the facility about 8 minutes ago. The resident had mental issues and hallucinations.
19:50 (7:50 p.m.) The complainant was looking for the subject.
20:01 (8:01 p.m.) The complainant advised other staff found subject.
20:01 The subject was okay and there were no injuries.
20:03 (8:03 p.m.) The subject and other staff were getting ready to walk back to the building.
20:03 The call was completed.

There was no documentation to indicate an adverse incident report was completed for resident #6's elopement o . . . . . .

Review of Agency for Healthcare Administration website to access adverse incident reports on revealed there were no incident reports submitted for residents #2 or #6.

In an interview conducted on at 4 PM with the administrator, she stated that the facility had never had any elopements prior to resident #1 eloping on and there were no adverse incident reports completed for any incident. The administrator did not divulge any information at that time that resident #6 had also eloped on . . . . . .

Unclassified

0167-Resident Contracts 58A-5.025(1) FAC
Based on record review, observation and interview, the facility failed to execute a contract at the time of admission with 1 of 6 residents reviewed (#6).

Findings:

Interview conducted on . . . . . at 2:40 PM with Administrator who stated that Resident #6 was not a resident of the facility. There was no actual file/record for the resident. The "man was an independent/ boarder", with no rental agreement. He resided in the first . . . . . the left as you entered the front door, which had never been an ALF . . . . . Administrator stated that she kept resident #6 ' s medications secured in the garage and that she put the pills in a pill box and gave the pill box to him in the AM and PM.

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Resident #6's Assisted Living Facility Health Assessment Form (1823) dated indicted diagnoses of and . The resident's or behavioral status was, service requirements read, "needs assist of caregiver with all care with meds." The 1823 form indicated the resident was independent with ambulation, bathing, dressing, eating, toileting and transferring. Page 4 of the 1823 form read, "Does the individual need help taking his or her medications?" "Yes" was checked.

In a telephone interview on at approximately 2 PM with the physician's office representative, she indicated the physician completed the 1823 form and said, on page 4 of the 1823 dated on the physician checked off "yes", the resident needed help with medication.

There was no documentation to indicate a resident contract had been completed for resident #6. The resident required assistance with self-administration of medications, was an Assisted Living Facility resident, and required a resident contract to be completed.

Class III

0190-Administrative Enforcement 58A-5.033 FAC
Based on observation, record review and interview, the facility staff refused to answer any questions during the complaint investigation for 1 of 6 sampled residents (#2) who had multiple elopements from the facility.

Findings:

The Agency for Health care Administration (AHCA) received information that resident #2 had multiple elopements from the facility.

In an attempted interview with staff #A on at approximately 10:15 AM, she told the surveyor to wait for the administrator who was outside of the facility, to come in and answer questions regarding the elopement. Staff #A was asked to answer questions on at approximately 10:30 AM and at 10:55 AM. On at approximately 2 PM, staff #A again refused to answer questions.

Confidential interview #1 on at approximately 12:05 PM revealed the interviewee had spoken to Adult Protective Services, the police and other organizations many times about problems at the Assisted Living Facility (ALF). On , the interviewee said an elderly male, later identified as resident #2, was observed breaking out a facility window at approximately 3:45 PM. He exited the

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facility through the window, stated he was locked in his day and could not get out, was standing out in the rain, seemed to be talking to a tree, and began to do calisthenics and push-ups. During that time, no staff member came outside to get the resident. The interviewee observed the resident outside of the facility for over an hour on On there were helicopters out looking for another resident who escaped (later identified as resident #1). Resident #2 was observed kicking wood panels out of the facility window at the same time the helicopters were overhead. The resident was observed kicking out a facility window, leaving out the window several times and leaving the ALF property. A resident had tried to get into a nearby home. When the interviewee attempted to inquire at the facility, they did not answer the door.

Review of resident #2's 1823 form dated indicated diagnoses of non-specific, left and lung nodules. The physical or sensory limitations stated: The or behavioral status stated: alert and oriented to person, he was suspicious, and labile. The special precautions stated: precautions. The resident was independent with ambulation, bathing, dressing, eating, toileting and transferring.

Resident #2 was observed on at approximately:
10:45 AM The resident was asleep in his his bed. The window had been kicked out and there was no glass in the window. There was an armoire pushed up to the window to cover the hole.
1:00 PM The resident was observed ambulating in the facility attempting to play his guitar. An interview was attempted, the resident spoke in another language, was constantly redirected to speak in English would forget mid-sentence and then revert to his native language. The resident stated he broke his window out so that he could "escape" from the facility. The resident did not know where he was, or why he was there. He wanted to go visit his family in Hialeah. As the afternoon went on, the resident became increasingly agitated and aggressive toward other residents and was banging on his guitar.

Resident #2 had a previous history of elopement from the facility as follows:
Elopement
Review of an Orange County Sheriff's Office (OCSO) Inquiry Response report #132492710 dated stated the call was initiated at 16:45 (4:45 p.m.) and revealed:
Location: 13230 Early Frost Circle, Orlando
16:51 (4:51 p.m.) Entry - Male was in front yard boxing, talking to trees and vehicles. Came outside through his
17:14 (5:14 p.m.) Resident #2 was endangered and found on Crown Hill Boulevard/Willow Branch next intersection north of Early Frost.
17:38 (5:14 p.m.) OCSO was on the scene.
18:01 (6:01 p.m.) Closed.

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Elopement
Review of OCSO Inquiry Response report #132532080 dated stated the call was initiated at 13:13 )1:13 p.m.) and revealed:
Location: 13230 Early Frost Circle, Orlando.
While OCSO was investigating the elopement of resident #1, resident #2 kicked out his

16:44 (4:44 p.m.) Another resident (resident #2) broke out the window, which required another unit to be dispatched.
16:46 (4:46 p.m.) On scene

Review of the 2013 Work Schedule revealed staff #A worked on from 8 AM to 8 PM when resident #2 eloped from the facility at 4:45 p.m. Staff #A also worked on from 8 a.m. to at 8 a. m., when resident #2 eloped from the facility again at 4:46 p.m. However, staff #A refused to answer any questions and deferred all questions to the administrator regarding the elopements and any other questions asked of her.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Avalon's Assisted Living II
13230 Early Frost Circle
Orlando, FL 32828

Dear Administrator:

Re: Complaint Inspection - CCR #2013009505

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 .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure: State Form
XG90

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