RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2014

. . . Marilou Zananski, Administrator
Leisure Manor ALF
301 South Main Avenue
Minneola, FL 34755

Dear . . Zananski:

This letter reports the findings of a complaint inspection survey (CCR# 2013013449) completed on . 2014, by a representative of the Agency for Health Care Administration (Agency). Enclosed is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **ten business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other

Directed Corrective Actions:

1. The Assisted Living Facility is required to immediately provide all residents identified as at risk for elopement with identification information as described in 58A-5.0182(8) FAC. Each resident identified as at risk for elopement shall receive an identification bracelet with the individual resident's name, the name of the facility, the address of the facility and an accurate phone number for the facility. Staff will ensure residents are wearing their identification bracelets on a daily basis.

2. The Assisted Living Facility is required to evaluate all residents to determine their individual risk for elopement. Residents who are assessed as at risk for elopement shall receive a second evaluation by a health care provider (as defined by 58A-5.0131(15) FAC). The health care provider shall determine and document if the needs of these resident(s) can be met at facility which does not have a secured unit. All residents determined to need placement in a facility with secured unit shall be appropriately discharged from the facility to a facility with a secured unit within 10 days of the resident(s) assessment by the health care provider.

3. The Assisted Living Facility is required to evaluate all residents, as indicated in your current policy, every six months for their individual risk for elopement. Documentation of all evaluations shall be maintained on the premises of the facility at all times and be available for Agency review. As a part of the evaluation process and ongoing monitoring, staff shall document changes in behaviors of residents identified as elopement risk. All documented changes shall be reported to the administrator and/or manager. When a resident is identified as an

elopement by the facility, the resident shall receive a second evaluation by a health care provider (as defined by 58A-5.0131(15) FAC). The health care provider shall determine and document if the needs of these resident(s) can be met at facility which does not have a secured unit. All residents determined to need placement in a facility with secured unit shall be appropriately discharged from the facility to a facility with a secured unit within 10 days of the resident(s) assessment by the health care provider.

4. The Assisted Living Facility is required to update the facility's elopement policy to include hourly checks on residents who are identified as elopement risk and who meet the criteria to remain in the unsecured facility. All checks must be documented with a date and time and shall be maintained on the premises of the facility for agency review.

5. The Assisted Living Facility is required to update the facility's admission policy to include the facility's position on the acceptance and/or retention of residents identified as an elopement risk.

6. The Assisted Living Facility is required to provide training for all staff on the facility's new policies and procedures related to elopement risk. The training(s) shall include interventions and prevention measures for residents identified as at risk for elopement. All training(s) and attendees must be documented and maintained on the premises of the facility for Agency review.

7. The Assisted Living Facility is required to provide sufficient lighting in the hallway of the second building and enclose the opening between the air conditioning unit and the window in (in the second building). The facility must receive a satisfactory report from the Lake County Health Department to meet this requirement.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call Jasmine Hayes, Health Facility Evaluator Supervisor, at (386) 462-6201.

Sincerely,

for

Kristie J. Mennella
Field Office Manager

KJM/jh

Enclosure

Received by: Date:

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

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

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910284	01/06/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Leisure Manor Alf	301 South Main Avenue Minneola, FL 34755	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= G
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D

Specific Tag Findings:

0000-Initial Comments

On , and a complaint inspection (CCR# 2013013449) was conducted at Leisure Manor, an assisted living facility. Deficient practice was identified at the time of the survey.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observations record reviews and interviews, the facility failed to provide the appropriate level of supervision for one of two residents identified as an elopement risk (Resident #2).

The findings include:

1. On at approximately 10:30 a.m. a tour of the facility was conducted. The facility was observed to have three entry/exit doors in the main building for resident use. All three doors were equipped with an alarm; however, the alarm on the door near the kitchen was . Residents were observed going in and out of the building throughout the day.

2. On at 2:02 p.m. Staff A was interviewed. Staff A stated Resident #1 had a tendency to walk away from the facility. Staff A stated on at approximately 2:30 p.m. Resident #1 told her he wanted to walk to the store. Staff A stated she advised Resident #1 not to walk to the store, because it looked as if it were going to rain outside. She stated Resident #1 agreed he was not going to wait to go the store. Staff A stated she went to look for Resident #1 around 4:30 p.m. and Resident #1 could not be located in the facility. She stated Resident #1 was not located until two days after he left the facility. Staff A also stated she was the only employee working in the facility on she added it is hard for her to supervise two buildings when she is the only employee on shift.

3. On at 4:47 p.m. Staff B was interviewed. Staff B stated the facility regularly allowed Resident #1 to leave the facility and walk to the store unsupervised. Staff B continued by saying she was worried about Resident #1 during his elopement from the facility (on because Resident #1 ' s gait is unsteady and he staggers while walking. Staff B added she was worried Resident #1 would down and hurt himself. Staff B stated the police were unable to locate Resident #1 between and she confirmed the police were notified and a search party went to look for Resident #1. Staff A added Resident #1 was located on by a stranger who found Resident #1 walking and picked him up then returned him to the facility.

4. On 5:04 p.m. an interview was conducted with one of Resident #1 ' s physicians (Physician #1).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910284	01/06/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Leisure Manor Alf	301 South Main Avenue Minneola, FL 34755	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Physician #1 reported Resident #1 does not have the capacity to make decisions or judgments on leaving the facility and should not have been allowed to leave the facility unsupervised.

5. On at approximately 11:22 a.m. an interview was conducted with the Administrator, she stated when Resident #1 was admitted to the facility he was determined by the facility to not be at risk for elopement, she added it was not until later in the month when the facility assessed Resident #1 as an elopement risk.

6. On at approximately 12:30 p.m. Physician #2 was interviewed. Physician #2 stated he was the admitting physician when Resident #1 was arrived at the hospital on Physician #2 stated upon admission Resident #1 was observed to be and displayed a poor verbal ability. Physician #2 reported Resident #1 was admitted with a diagnosis of severe Rhabdomyolysis (the breakdown of muscle tissue) and acute kidney failure. Physician #2 reported it was clear to him the onset of Rhabdomyolysis was caused by Resident #1 walking for an extended period of time which led to muscle damage. Physician #2 reported the Rhabdomyolysis caused the Resident #1 ' s acute kidney failure.

7. On at 5:38 p.m. an interview was conducted with Physician #3. Physician #3 confirmed she assessed Resident #1 on and confirmed she documented Resident #1 wanders and gets lost on his health assessment.

8. A Review of Resident #1 ' s health assessment (dated revealed Physician #3 documented Resident #1 ' s and behavior status as, " undifferentiated type and " Continued review revealed Resident #1 was documented as, " [Resident #1] wanders and gets lost, [Resident #1] is a risk. "

9. A review of Resident #1 ' s Plan of Care: Elopement Prevention report revealed on Resident #1 was identified by the facility as an elopement risk with exit seeking behaviors.

10. A review of adverse incident reports from the facility revealed on Resident #1 eloped from the facility. A review follow-up (15 day adverse incident report) revealed Resident #1 was later found near a lake. The facility identified this incident as an elopement and documented their corrective/protective actions would be to, " Keep a close eye on him (Resident #1), make sure alarms are set if doors, check exit doors and resident every half hour. "

11. A review of Resident #1's Resident Observation Log revealed on at approximately 11:30 p.m. Resident #1 requested to leave the facility. Resident #1 was told he could leave the facility after lunch. Continued review revealed at approximately 1:15 p.m. Resident #1 was observed in bed playing with his music. At approximately 2:45 p.m. another resident reported seeing the Resident #1 in the facility and at approximately 4:35 p.m. Resident #1 could not be found in the facility. Continued review of Resident #1's Resident Observation Note revealed on at 2:00 p.m. Resident #1 was dropped off at the facility by a woman who found Resident #1 walking and, " looking as if he was going to pass out. " Resident #1 reported he walked to Orlando

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910284	01/06/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Leisure Manor Alf	301 South Main Avenue Minneola, FL 34755	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

and back.

12. A review of the local sheriff ' s office police report revealed on the facility contacted the sheriff 's office and reported Resident #1 as missing. The report confirms Resident #1 reported he walked to Orlando, Florida and was returned by a female who picked the resident up while he attempted to walk back to the facility. Continued review of the report revealed reported the police have searched for Resident #1 approximately 5 or 6 times in the past and noted Resident #1 missing from the facility as, " a continual issue " .

13. A review of Resident #1's emergency revealed on Resident #1 was presented to the emergency of generalized Resident #1 was admitted to the hospital and diagnosed with severe , rhobdomyolysis, and acute kidney failure. A review of Resident #1' s hospital notes revealed Resident #1 reported he walked to Orlando, Florida, had not eaten and was given one glass of water while he was away from the facility. Resident #1 also reported he and hit his head while he was away from the facility. Resident #1 also reported to the emergency he was robbed while he was away from the facility.

14. A review of the facility ' s elopement policy and procedure revealed the facility defines elopement as, " when a resident leaves the facility. "

Class II

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC
Based observation record review and interviews, the facility also failed to follow their policy to assess two of two residents identified as elopement risk every six months (Resident #1 and #2). The facility also failed to make a daily effort to ensure residents identified as an elopement risk had identifying information on their persons which includes the facility ' s information for two of two residents in the facility (Resident #1 and #2).

The findings include:

1. On a review of the facility ' s elopement policy and procedure revealed all residents will be evaluated upon admission and every six months thereafter for risk of elopement and the facility will initiate individualized interventions to address risk for elopement.

2. On a review of Resident #1 ' s facility record, revealed Resident #1 was admitted to the facility on A review of Resident #1 ' s health assessment revealed on Resident #1 was assessed by a physician with the assessment stating, " Patient wanders away and gets lost. " A review of Resident #1 ' s Plan of Care: Elopement Prevention revealed on the facility assessed Resident #1 as at risk for elopement and noted Resident #1 displayed, " exit seeking " behavior. There were no other elopement assessments in Resident #1 ' s record.

3. A review of a 1 day and 15 day adverse incident report revealed Resident #1 eloped on

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910284	01/06/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Leisure Manor Alf	301 South Main Avenue Minneola, FL 34755	

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

4. A review of the county sheriff ' s office report revealed the facility called in a missing persons report on after Resident #1 could not be located within the facility. Continued review of the report revealed the police have searched for Resident #1 approximately 5 or 6 times in the past and noted Resident #1 missing from the facility as, " a continual issue. " Continued review of the report revealed Resident #1 was located two days later on

5. A review of Resident #2 ' s facility record revealed Resident #2 was admitted to the facility in A review of Resident #2 ' s Plan of Care: Elopement Prevention (undated) revealed Resident#2 was assessed as an elopement risk and noted as having, " exit seeking " behavior. There are no other assessments in Resident #2 ' s record.

6. On at 11:36 a.m. Resident #2 was observed in the facility. Resident #2 did not have identifying information on her.

7. On at 11:44 a.m. an interview was conducted with the Administrator. She confirmed the facility does not provided residents listed as at risk for elopement with identifying information on a daily basis.

Class II

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC
Based on observation, interview and record review, the facility failed to ensure all structural systems were maintained in in good working order.

The findings include:

1. On at approximately 10:30 a.m. a tour of the facility was conducted. Observation of the second building revealed there was no light when entering through the front door. The air condition (AC) unit in (of the second building) is not properly enclosed, a gap between the AC unit and the window was observed.

2. On at approximately 12:25 p.m. an interview was conducted with an Environmental III from the Department of Health. The Environmental III stated the facility has missing light bulbs in the main hallway. She added there is a gap between the window AC unit and the window which needs to be closed. The Environmental III reported failure to close the gap around the AC unit the allow pest into the facility, she added closing the gap will be a form of vector control. The Environmental reported on she made the facility aware the above repairs need to be made.

3. A review of the Department of Health inspection report revealed on the facility received inspection violations for not replacing a light bulb in the second building, not closing the opening around the AC unit in and not repairing the the water stain on the ceiling in (second building). The report states the above issues were also discussed with the facility on

Class III