STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910126	10/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

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= J
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 - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0167 - 58a-5.025 Fac - Resident Contracts S-S= B
St - A - Z821 - 59a-35.110, Fac - Reporting Requirements; Electronic Submission S-S= C

Specific Tag Findings:

0000-Initial Comments

The Relicensure survey with Limited Nursing Services (LNS) was conducted on [redacted] and [redacted] in conjunction with Complaint Investigations #2014008458 and #2014009646. Grand Villa of Altamonte Springs Assisted Living Facility had deficiencies found at the time of the visit.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on observation, record review and interview, the facility administrator failed to ensure that 1 of 25 sampled residents at risk of elopement was appropriate for placement in the facility (#3).

Findings:

Resident record review conducted on [redacted] at approximately 3:00 PM for resident #3 revealed a Facility Health Assessment Form (AHCA 1823 Form) dated [redacted] with diagnosis of [redacted] and [redacted]. The physician indicated that the resident was independent in activities of daily living (ADL) care with supervision noted for ambulation and bathing. The physician noted that the resident was independent in taking his medications. The most recent Facility Health Assessment Form (AHCA Form 1823) dated [redacted] indicated diagnoses of [redacted] femur, generalized [redacted] hip surgery and prostatic hypertrophy [redacted]. The physician indicated that the resident had some [redacted] and ambulated with an assistive device, a walker. He required assistance with all ADLs and assistance in handling personal and financial affairs. Daily oversight was required for observing well-being, remembering important tasks, and observing whereabouts.

Nurse's note dated [redacted] revealed resident was observed on the floor in the main dining [redacted]. The resident stated he slipped. The resident was sent to emergency [redacted]

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evaluation and returned to the facility. On , the resident ... on the floor and no injuries were noted. On the resident left the property with another resident. The incident is considered an elopement. The resident did not follow the facility procedure of signing out. He returned and the administrator discussed safety issues with him. The resident called his pastor and spoke with the pastor regarding the concerns.

On the resident left the facility sometime after 7:00 AM medications. His whereabouts were unknown until 7:10 PM that evening. The resident had walked to the Altamonte Mall and back, crossing Highway SR 436, an eight lane highway, using a walker.

In an interview on at 6:30 PM with the facility administrator, she stated resident #3 had been leaving the facility without following facility procedure of signing out. The administrator stated that she had spoken with the resident's family members and they had been looking for placement out of state. The administrator planned to give the resident a 45 day notice of discharge because the facility cannot meet his needs. The administrator did not monitor the continued appropriateness of placement in the facility at all times.

Class II

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, record review and interviews, the facility:
1. Failed to provide an adequate system of supervision to meet the needs through proactive measures to minimize the potential for risk of harm for 2 of 25 sampled residents (#3 & 23), who were , had previously eloped from the facility and walked across an 8 lane highway State Road (SR) 436 in the dark with his walker (#3), and who left the facility twice in one day and was found near Highway SR 436 (#23).
2. Failed to inform and document that the Home Health Care nurse was notified when resident #3was picking and scratching at a with the dressing in place. The facility had a Limited Nursing Services license and did not provide ... assessment and ... care to the resident when the integrity of the dressing was compromised, enabling maggot infestation of the ... for 1 of 25 sampled residents (#4). The facility failed to inform the healthcare provider when 1 of 25 sampled residents had a significant change (#18).
3. Failed to inform and document the healthcare provider was notified of significant changes for 1 of 25 sampled residents (#18).

Findings:

1. During tour of the facility on at approximately 10:30 AM, it was learned that resident #3 was missing from the facility. In an interview conducted on at 11:20 AM

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with the administrator, she was asked the whereabouts of resident #3 and stated he was out of the building. When asked where, she stated she would have to look in the sign out book.

On at 12:20 PM, in an interview with the administrator revealed resident #3's family was supposed to pick him and his wife up this morning for a family funeral. The family arrived at 9 AM but resident #3 was not in the facility. He was supposed to go to breakfast and did not show up. The family suggested to the administrator that he might have gone to the ship. The family did not have specific information. The administrator called the cruise line to determine if the resident was on the ship. The administrator stated that the resident left the facility sometime after receiving morning medications, without following the facility procedures of signing out when leaving the facility. The administrator stated that the director of nursing (DON) also stated on that resident #3 left the facility with another resident without signing out. The administrator said the resident had a history of doing this since he was admitted on

Resident #3's record review revealed a Facility Health Assessment Form (AHCA Form 1823) dated with diagnoses including femur, generalized , hip surgery, prostatic hypertrophy , ambulates with assistive devices and some He required assistance with all activities of daily living (ADLs) and assistance in handling personal and financial affairs. Daily oversight was required for observing well-being, remembering important tasks, and observing his whereabouts.

Review of the nurse's note dated revealed resident #3 left the facility with another resident to go to the cruise ship to gamble. It was noted that upon return, the resident was cautioned about safety and following the facility procedures.

Review of the sign out/in log at 1 PM on revealed that resident #3 was not signed out for today's date,

Review of the facility Elopement Policy and Procedures on read, that "the residents would be considered to have eloped when the resident left the facility without following the facility policies and procedures."

A telephone call placed on at 2:24 PM to the Seminole County Sheriffs Department Elder Crimes Investigator who was informed of the current situation at the facility. Information requested was provided to the deputy. During the conversation, the deputy stated she would come to the facility to investigate.

The deputy investigator arrived on at 2:30 PM and called the resident's family

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member who stated that she did not know the exact whereabouts of resident #3 at this time. She stated there was a reservation message found on the resident's telephone voice mail stating Mears Taxi Company was supposed to pick him up this morning. The family member believed he was on the Victory cruise ship, and supplied the investigator with his Very Important Person (VIP) Player Identification (ID) number. The family member stated the resident did not have a cell phone. The officer contacted the Mears Taxi Company and learned that a taxi did arrive at the facility address at 7:40 AM on , and the resident did not come out. The driver called the number given for the resident and no one answered. The cab left without the resident. The administrator provided the investigator with a copy of a boarding pass she was able to obtain from Victory Casino Cruises dated Tuesday with a Departure Time of 11 AM. The boarding pass did not indicate whether or not resident #3 actually arrived on the ship. The investigator called the main office of the cruise line and was able to determine at approximately 5 PM, resident #3 had arrived on the ship at 10:32 AM. He arrived via their shuttle bus that picked him up at the Altamonte Mall. He got off the ship at 4 PM and got back on the shuttle bus to be taken back to the Altamonte Mall. The administrator stated on at approximately 6:00 PM she had a staff member waiting for him at the Altamonte Mall, waiting to drive him back across highway SR 436. The investigator left the facility at that time. However, the staff was allowed to leave the Altamonte Mall at 7 PM without resident and resident #3 whereabouts were unknown.

Interview conducted on at approximately 6:30 PM with the administrator who stated that the staff member who was waiting at the mall was not able to locate the resident. He was still not back at the facility. The administrator stated she would call the police to report him missing if he did not return in the next half hour.

In an interview conducted on at 7:10 PM with the administrator, she stated the resident had been seen at the Publix supermarket behind the facility and was on his way into the facility.

An interview on at 7:30 PM with resident #3 was attempted but he stated he was out to see his attorney. The resident stated further that he was tired and he asked to be left alone.

Interview was conducted on at 9:50 AM with resident #3 who eloped from the facility on and Resident #3 stated he knew he made a mistake and should have signed out. At first being questioned about what happened on he initially stated he had gone to see his physician and attorney. When he was informed him that the police had determined he was in fact on the cruise, he then stated it was no one's business. When asked how he got to the Altamonte Mall, he stated it was no one's business. He was agitated and at times. When asked who drove him home from Publix, he became

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angry and stated no one drove him anywhere, a bus dropped him off at Sears, behind the Altamonte Mall. It was dark and pouring rain. He walked home across Highway SR 436. He said a car almost hit him. He was soaking wet and exhausted and stated he was short of breath. The resident was asked if he had identification on his person. He took a stack of cards out of his shirt pocket. One was an old driver's license that had an old address on it. He then pulled out several credit cards and stated the balance on each card. The resident had no identification with his name, the facility name, address and telephone number on it. The resident stated his age, 93, and that he was rich and could do what he wanted to do. He admitted he made a mistake by leaving and not signing out. The resident became angry and stated that he had money stolen from the facility. He stated that he placed $18,000.00 under his pillow last night and it was stolen. He called the police and they did not believe him.

Review of facility elopement logs on at 10 AM revealed that resident #3 was identified as an elopement risk on . A second book was produced with 8 residents who were assessed as an elopement risk. All eight residents resided in the memory care unit.

Review of facility's Adverse Incident Report Log on revealed that there have been no Adverse Incident Reports filed in the past two years.

In an interview conducted on at 10:30 AM with the administrator, she stated that on , she informed the resident and his family that he was an elopement risk and that he must have a 24 hour sitter. The resident stated that he would not pay for a sitter. At that time, the administrator had the resident on hourly checks. She stated she was not aware he had no identification on his person. The administrator provided a copy of 45 day Notice of Discharge. The administrator said the resident had capacity and could make his own decisions.

A review of the medical record revealed that the resident was admitted to the facility on with an AHCA 1823 Form that described him as completely independent in all ADLs, able to independently manage his medications, and required little or no oversights. On , the resident and sustained a femur. He was sent to a nursing home for rehabilitation after repair of the femur. The resident returned to facility on with an AHCA 1823 Form that indicated there was a decline in his condition and he required more care and services. Review of nursing notes from to the resident sustained five after returning from the nursing home.

According to documentation in the nurses notes dated , the resident was sent to hospital for . The resident returned from the hospital on with an AHCA 1823 Form indicating he required more care, required precautions, and had some

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On , the facility faxed a request to the resident's Veteran's Administration physician for a request for a hospice consult and a consult. During an interview on at approximately 4:30 PM with the administrator, she stated she did not know the exact reason for the consultation requests but they were still waiting for an appointment. The administrator agreed the resident had a significant change in status.

On , resident #3 left the facility with another resident who drives. In an interview with the administrator on at approximately 4:30 PM she stated resident #3 originally offered the other resident $260.00 to drive him to Cape Canaveral, 60 miles away. The ship was not running that day and the resident paid $120.00 for the trip. Once resident #3 was found missing on and it was determined that he had left with the other resident, the administrator was able to call the other resident on his cell phone to determine their whereabouts. Upon return, resident #3 was spoken to regarding the safety concerns. The administrator stated that the resident's family member was angry with him because he missed the funeral and chose to go instead. The administrator stated she called the resident's pastor who has been helpful in the past with interventions.

In an interview conducted on at approximately 11 AM, the DON was asked why the facility made a request for hospice evaluation and a consultation for resident #3 on She stated that the resident had a significant change in status and a decline in his behavior. He had been more agitated and belligerent to staff since his return from the nursing home. She said hospice refused to do the consultation because he did not have a diagnosis and the Veteran's Administration was mailing an appointment to the facility for the appointment.

In an interview on at 12 PM, the administrator was asked to describe the facility policy on what happens when a resident is deemed to be an elopement risk. She stated that the facility would require the resident to have a 24 hour sitter. The facility would seek to place the resident in their secured unit. If they do not have a bed in their secured unit, they will reach out to sister facilities to see if any of them have a bed in their secured units until a bed opens up at their facility.

In an interview at 4 PM on , the pastor and assistant pastor of resident #3 stated that they have been in contact with the resident's family. At that time, the family member was contacting facilities out of state where the family member had been seeking placement for resident #3. She planned to move him to one of these facilities as soon as possible. She was thinking the next day. The pastor had talked to resident #3 and the resident had agreed to pay for the airline ticket to go out of state. The pastor said he would drive the resident to the

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airport and ensure he got on the plane.

In an interview on at 5 PM, the administrator stated she had made arrangements with an agency to provide 24 hour supervision of resident #3. She provided a copy of the invoice to the survey team. Resident #3 would not allow anyone to stay in his the aide could sit outside his I alert the facility staff if he attempted to leave the property. She said she was communicating with the resident's family member to provide documentation of transfer to any facility who wanted to consider him for transfer.

2. Record review for resident #23 revealed a Resident Health Assessment form (1823) dated and noted diagnoses of and She required assistance with bathing, dressing and A physician's note dated noted she also had

A resident condition log noted the following:
PM - Resident Identified as elopement risk, called family member (name mentioned) to notify. Suggested 24 hours caregiver is obtained provided name and numbers for two. Spoke with him about possibility of moving resident to our memory care unit staff to check whereabouts frequently will continue to monitor.
PM - resident observed walking down Orange Drive (the street in front of the facility) in the rain by the staff, brought back to community. Voicemail for son (name mentioned). To monitor more frequently
- (no time) - resident observed walking to street sign at the edge of this property. She was re-directed back before exiting the grounds.
- (no time) this writer spoke with resident son (name mentioned). He was informed re-wandering and that the manger is requesting hire a sitter. He inquired regarding memory care and was given phone # and some names of agencies with sitters. He will call manager in AM.
- Physician's telephone order/status report-resident observed walking in front of Auto Zone in the rain. States she was going home. Next day she was redirected going to the stop sign in front of facility and walking left. Physician responded - consider transfer to memory care.

Incident Reports:
The incident report noted on at 3:40 PM - the staff was walking to bus stop. The resident was seen by auto zone walking in the rain. She said she was going home.
Another incident report noted on at 4 PM - The same staff that found her at auto zone noted-" I was leaving and saw her at the stop sign.

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A resident condition log noted the following:
- staff reported resident up out of bed at 3:30 AM. Stated she wanted to go home. She was sitting in the common area. The med tech (medical technician) had to answer a call and asked her to wait a minute. Returned and resident was gone. The staff located her using the main dining The lights were out and only dim night lightning. Son (name mentioned) was called and asked if he could get a sitter for 4 hours each evening until resident transfers to memory care. He agrees.
- resident had sitter in place from 4 PM-10 PM from senior bridge services. They will remain each evening 6 PM-10 PM until memory care is available.
- resident was relocated to in memory care.

During an interview with the dishwasher on at approximately 1:25 PM he stated on when he was leaving work and was walking to catch the bus towards the mall that was across the street. It was pouring rain and he did not have an umbrella. 'He stated he heard someone say hey", he looked over while walking and observed resident #23. She was down by auto zone. He told the resident it was raining and asked her where she was going. She told him she was going home. 'He told her okay. Let's go back home". He stated he walked the resident all the way back to the facility and gave her to a staff member. He stated Resident #23 was

During an "interview with the shift coordinator" on at approximately 2:30 PM he stated the resident was identified as an elopement risk on because she was exit seeking. He was asked if there was any documentation of the previous exit seeking incidents and he replied no. He stated on at 5 PM he observed the resident going out to the corner of the entrance at the stop sign and redirected her back.

During an interview with the administrator on at approximately 5 PM, she stated when a resident was exit seeking, the policy was to put a sitter in place until they could be placed in the memory care unit. She stated she was out of town when the incidents on happened and she thought that the staff was walking along with the resident. She was not aware that the resident was found by the staff at the Auto Zone.

Resident #23 was identified as exit seeking on . There were no notes in the record that indicated what events had occurred to determine that she was an elopement risk until Resident #23 was exit seeking, left the facility on at approximately 1:25 PMand was found by a staff approximately a half of a mile away from the facility in the rain on a road with a heavy volume of traffic. The same day she was found by another staff attempting to leave the facility again at around 5 PM. On she attempted to leave the facility again. On

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, the health care provider noted "consider transfer to memory care". The resident was not placed into memory care until . . . The facility notes documented that she had a sitter on . . . . from 4 PM-10 PM. There was no documentation of any proactive interventions/measures that were put in place to ensure that the resident who was exit seeking remained safe other than frequent monitoring and a sitter from 4 PM-10 PM. There was no documentation to confirm that the health care provider was contacted regarding the significant change in the resident's behavior that caused her to be assessed as an Elopement Risk until . . . . .

3. During entrance conference on . . . . . at approximately 9:45 AM with the Resident Care DON, resident #4 was identified as receiving Home Health Care skilled nursing visits for . . . . . care to the right lower extremity.

In an interview with the resident's family member on . . . at approximately 1 PM, he stated the resident was sent to the hospital for severe right lower extremity pain.

In a phone interview with the Seminole County Sheriff's Office investigator on . . . at approximately 1:30 PM, she stated resident #4 was in the Emergency . . . (ER). When the dressing was removed from the right lower extremity, there were maggots in the . . . . . She also stated the Adult Protective Services investigator had seen the resident at the ER.

Review of facility note dated . . . . . revealed the resident complained of leg pain and was sent to the hospital for evaluation and treatment.

Resident record review revealed an Assisted Living Facility Health Assessment Form (1823) dated . . . . that indicated diagnoses of . . . . and . . . . The resident was independent with ambulation, bathing, dressing, ... eating, toileting and transferring and needed assistance with self-administration of medications.

Review of a physician order dated . . . revealed HHC nursing visits twice a week for three weeks, then once a week for five weeks.

Review of the Home Health Care (HHC) nursing visit notes revealed the . . . . . developed on , the HHC nurse admitted the resident on . . . . and performed . . . . . care to the right lower extremity on . . . . . and . . . . . .

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Review of the HHC nursing note stated late entry for visit on The appeared clean and dry and intact. Instructed staff and patient to avoid removing dressing, picking at wounds, and keep dressing clean, intact and dry, and elevate lower extremities. The resident was of The staff stated the resident removed the dressing when the nurse left. The was assessed and was intact with a small amount of drainage, 50-75% epithlialization, no tissue, 0-25%, tissue eschar 0-25%, and no The location right lateral aspect, and was a

In a phone interview on at 8 AM, the HHC nurse stated the facility nurse informed her the resident removed the dressing after she left the facility. The resident sat outside in the sun, most of the day and would smoke. She would go to the dining meals and then return outside. The was healing on her last visit on and the dressing was intact when she arrived for care. The dressing was changed on her weekly at that time. A culture was obtained a few weeks ago and it was negative.

Review of the Emergency Physician Record dated at 7:07 AM noted the resident had pain in the right leg in the past 24 hours. She had 2 dressings on the area of her pain. The patient stated it was the "worst pain of her life." The patient usually walks with a walker. The pain was moderately severe. The right lower leg had (redness). Four live maggots were removed from the right lower leg. The clinical impression was and maggot infestation.

Review of the History and Physical dated noted the resident presented to the emergency (ER) with a painful, right leg for the past several days. The ER physician examined the right lower leg and found an that contained several maggots. The patient was given and was admitted for further evaluation and treatment. The clinical impression was right lower extremity, with of the right lower extremity, and

Review of the Consult Report dated revealed the resident had gram negative rod bacteremia, which may still be a contaminant but cannot rule out the possibility of bacteremia from the right lower extremity advanced age, and

The physical exam revealed a quarter sized with a little black spot on the side and some at the base on the outside of the right leg. The resident was treated with Zoysn, an

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In a phone interview on at approximately 10:55 AM, the DON stated the resident would open the dressing, pick at the and put the dressing back on. The resident did not remove the dressing. She also stated the HHC nurse provided the care to the resident. The resident went to meals and sat outside most of the day and smoked.

In a phone interview with the staff nurse/shift coordinator on at approximately 11 AM, he stated the HHC nurse provided the care to the resident. He also stated the resident would pick and scratch at the when the dressing was on. The resident would go to the dining meals and then sat outside during the day and would smoke. The resident had to be cued to go to her incontinence care.

Review of facility notes dated (no year) revealed the resident was alert with

There was no documentation to review that indicated the HHC agency or healthcare provider was notified that the resident was picking and or scratching the when the dressing was on, removed and replace the dressing. There was no documentation that indicated the was redressed when the resident compromised the integrity of the dressing.

4. Resident record review for resident #18 revealed an 1823 dated and updated on the indicated diagnoses of and Parkinson's

Review of facility note dated at 5:20 PM revealed the resident was observed sitting on floor in his apartment, a hematoma was noted to back of head. The resident was sent to hospital for evaluation and treatment. There was no documentation the physician was notified or the date of return from the hospital was noted.

Review of facility note dated on the resident called the family member on the phone and was heard telling the family member that he wanted to get out of the community or he would kill himself. The staff was instructed to keep him in the common area and to be aware of his whereabouts and his activities and do frequent There was no documentation the physician was notified of the resident's comments.

In an interview on at approximately 5 PM, the administrator said she was not aware the physician was not notified.

Class I

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0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC
Based on observation, interview and record review the facility failed to ensure residents who were identified at risk (AR) of elopement had identification (ID) on their person that included their name, the facility's name, address, and telephone number for 9 of 9 sampled AR residents (#3, 17, 19, 20, 21, 22, 23, 24 & 25).

Findings:

During an interview with resident #3 on at 9:50 AM revealed resident #3 stated was given a written 45 day Notice of Discharge. He further explained that the facility stated he had eloped from the faciity on and He was informed he had to have a 24 hour sitter and refused to pay for one. Resident #3 did not have any form of identification on his person to indicate his name, the facility's name and address and phone number.

In an interview conducted on at 10:30 AM with administrator who stated that the resident refused to pay for a 24 hour sitter. The administrator put in hourly checks around the clock. Staff would check on the resident every hour. She provided a 45 day Notice of Discharge to the resident and his family as the facility can no longer meet his needs.

Observation on at 9:30 AM of resident #3, who was identified as an elopement risk, revealed that the resident was not wearing an identification bracelet with the name of the facility, facility address or phone number.

2. Record review for resident #23 revealed that on it was determined she was an Elopement Risk.

The facility's elopement policy and procedure noted an elopement was when a resident left the building without following the facility's policy. This included signing out each time they left the building. Further record review revealed that the health care provider noted on that she had a diagnosis of

An incident report noted on at 3:40 PM that the staff walked to the bus stop and saw resident #23 by The Auto Zone store walking in the rain. The resident said she was going home.

During an interview with the dishwasher on at approximately 1:25 PM, he stated on when he left work and walked to catch the bus towards the mall that was across the street,it was pouring rain and he heard someone say "hey". He said he saw resident #23 by the Auto Zone store. He said he told the resident it was raining and asked her where she was

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going. She told him she was going home. He told her, "OK, let's go back home." He stated he walked the resident all the way back to the facility and gave her to a staff member. He stated resident #23 was

Resident #23 was observed on at approximately 12 PM, and did not have elopement ID on her person that met the regulatory requirements.

3. In an interview with the Memory Care director on at approximately 12 PM, residents #17, #19, #20, #21, #24 and #25, who resided in the Memory Care Unit (MCU), were identified as at risk of elopement. She stated their elopement IDs were checked at every meal and documented on the meal roster form.

Observation in the MCU on at approximately 12:05 PM revealed residents #17, #19, #20, #21, #24 and #25's elopement IDs did not include their name, the facility's name, address and telephone number.

In an interview on at approximately 5 PM, the administrator said she was not aware that these elopement risk residents' IDs did not have the required information. She also stated the residents' IDs were checked every morning in the MCU.

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 the management of all staff and the provision of adequate care to all residents:
1. Failed to ensure staff followed the facility elopement policy on two occasions when 2 of 25 sampled residents (#3 & 23) eloped from the facility and failed to ensure that a policy was in place to meet the needs of residents identified as elopement risk through proactive measures to minimize the potential for risk of harm. The facility failed to maintain appropriate identification on the resident's person with the residents name, facility name, adress and telephone for 2 of 25 sampled residents (#3 & #23).

2. Facility failed to inform and document the physician and Home Health Care nurse was notified when resident #4 was picking and scratching at a , with the dressing in place. The facility had a Limited Nursing Services license and did not provide assessment and care to the resident when the integrity of the dressing was compromised, enabling a maggot infestation of the for 1 of 25 sampled residents (#4). The facility failed to inform the healthcare provider when 1 of 25 sampled residents had a significant change (#18).

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3. Failed to ensure that residents who were at risk of elopement had identification (ID) on their person that met the requirements for 9 of 9 residents (#3, 17, 19, 20, 21, 22, 23, 24 & 25).

4. Failed to ensure 1 of 5 sampled staff had a statement from the healthcare provider that indicated she was free from all communicable (D).

5. Failed to complete new Assisted Living Facility Health Assessment forms (1823) when 1 of 25 sampled residents had a significant change (#18).

6. Failed to ensure the contract contained the required information regarding rights, duties and of residents for 1 of 25 sampled residents (#2).

7. Failed to ensure adverse incident reports were completed when law enforcement conducted an investigation for 3 of 25 sampled residents (#3, 17 & 23).

Findings:
1. Failed to ensure staff followed the facility elopement policy on two occasions when 2 of 25 sampled residents (#3 & #23) eloped from the facility and failed to ensure that a policy was in place to meet the needs of residents identified as elopement risk through proactive measures to minimize the potential for risk of harm. The facility failed to maintain appropriate for 1 of 25 sampled residents (#3).

Record review for resident #3 revealed a Facility Health Assessment Form (AHCA Form 1823) dated with diagnoses of femur, generalized hip surgery and prostatic hypertrophy. The physician indicated that the resident had some and ambulated with assistive devices (a walker). He required assistance with all activities of daily living, and assistance in handling personal affairs and handling financial affairs. He needed daily oversight was required for observing well being, remembering important tasks and observing whereabouts.

Observations and interview on at approximately 9:30 AM during tour of facility revealed that resident #3 had eloped from the facility.

In an interview on at approximately 10:30 AM, the administrator stated she did not believe this incident with resident #3 was an elopement. She stated that a resident is considered to have eloped if they do not follow the facility policies. Review of the elopement

policy revealed that residents will sign out when leaving the facility.

Review of the sign out/in log at 1 PM on revealed resident #3 was not signed out for that date.

Review of the facility's "Elopement Policy and Procedures" read, that "the residents would be considered to have eloped when the resident left the facility without following the facility policies and procedures." The elopement policy also stated that if a resident not found in the facility after a search, the resident's family would be called and the police would be notified.

On at 1:24 PM, a telephone call was placed by a survey team member to Elder Crimes Investigator, Sheriff, Seminole County who was asked if the Sheriff's Department had received any calls on regarding a missing person from the facility. She checked the system and there were no reports made regarding resident #3 being missing. She stated she would come to the facility to investigate.

Record review for resident #23 revealed that on , it was determined she was an Elopement Risk. The facility's elopement policy and procedure noted an elopement was when a resident left the building without following the facility's policy, which was signing out each time they left the building. Record review revealed that the health care provider noted on that she had a diagnosis of .

An incident report noted on at 3:40 PM that the staff was walking to bus stop, on her way home and saw resident #23 by the store Auto Zone, walking in the rain. During an interview with the dishwasher on at approximately 1:25 PM, he stated he left work and walked towards the mall that was across the street to catch the bus. He stated it was pouring rain and heard someone say "hey". He said he looked over while walking and observed resident #23 by the Auto Zone store. He told the resident it was raining and asked her where she was going. She told him she was going home. He told her, "OK, let's go back home." He stated he walked the resident all the way back to the facility and to a staff member. He stated resident #23 was

A resident condition log noted the following:

- staff reported resident up out of bed at 3:30 AM. Stated she wanted to go home. She was sitting in the common area. The med tech had to answer a call and asked her to wait a minute. Returned and resident was gone. The staff located her using the main dining The lights were out and only dim night lightning. (Son) was called and asked if he could get a sitter for 4 hours each evening until resident transfers to memory care. He

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agrees.

- resident had sitter in place from 4 PM-10 PM from Senior Bridge services. They will remain each evening 6 PM-10 PM until memory care is available.

- resident was relocated to memory care.

Resident #23 was observed on at approximately 12 PM and did not have elopement ID on her person that met the regulatory requirements.

In an interview on at 2:24 PM, the administrator was asked what the facility procedure was to protect residents when they were determined to be an elopement risk. The administrator stated that the resident who was identified as an elopement risk was asked to get a 24 hour sitter until the facility could place them in an appropriate setting. If the facility memory care unit had a bed available the resident would be placed there. If they do not have a bed, they would seek a bed in a sister facility as respite until they had a bed in their facility.

2. Facility failed to inform and document the physician and Home Health Care nurse were notified when the resident was picking and scratching at a with the dressing in place. The facility had a Limited Nursing Services license and did not provide assessment and care to the resident when the integrity of the dressing was compromised, enabling a maggot infestation of the for 1 of 25 sampled residents (#4). The facility failed to inform the healthcare provider when 1 of 25 sampled residents had a significant change (#18).

During entrance conference on at approximately 9:45 AM with the resident care director, resident #4 was identified as receiving Home Health Care skilled nursing visits for care to the right lower extremity.

In an interview with the Seminole County Sheriff's Office investigator on at approximately 1:30 PM, she stated resident #4 was in the Emergency (ER). When the dressing was removed from the right lower extremity, maggots were found in the

Review of facility note date revealed the resident complained of leg pain and was sent to the hospital sent to the hospital for evaluation and treatment.

Resident record review revealed an Assisted Living Facility Health Assessment Form (1823) dated that indicated diagnoses of , and The resident was independent with ambulation,bathing, dressing, , eating, toileting and transferring and needed assistance with self-administration of medications.

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Review of physician order dated revealed Home Health Care (HHC) nursing visits twice a week for three weeks, then once a week for five weeks. Review of the HHC nursing visit notes revealed the developed on The HHC nurse admitted the resident on and performed care to the right lower extremity on and

Review of the HHC nursing note dated on late entry for visit on The appeared clean and dry and intact. Instructed staff and patient to avoid removing dressing, picking at wounds, and keep dressing clean, intact and dry, and elevate lower extremities. Resident was of The staff stated the resident removed the dressing when nurse left. The was assessed and was intact with a small amount of drainage, 50-75% epithlialization, no tissue, 0-25%, tissue eschar 0-25 %, no The right lower leg was a

Phone interview with the HHC nurse on at 8:40 AM. The nurse stated the facility nurse informed her the resident removed the dressing after she left the facility. The resident sat outside in the sun, most of the day and would smoke. She would go to the dining meals and then return outside. The was healing on her last visit on and the dressing was intact when she arrived for care. The dressing was changed on her weekly at that time. The nurse stated she took the dressing off when I left. It was always on when I saw her. The weekend supervisor informed her the resident was taking the dressing off. The staff stated she refused to elevate her legs and sat in with it running down her leg and refused baths.

Review of the Emergency Physician Record dated at 7:07 AM noted the resident had pain in the right leg in the past 24 hours. She had 2 dressings on the area of her pain. Patient stated "worst pain of her life." Patient usually walked with a walker. The pain was moderately severe. The right lower leg had (redness). Four live maggots were removed from the right lower leg. The clinical impression was and maggot infestation.

Review of the History and Physical dated noted the resident presented to the emergency (ER) with a painful, right leg for the past several days. The ER physician examined the right lower leg and found an that contained several maggots. The patient was given and was admitted for further evaluation and treatment. The clinical impression was right lower extremity, with of the right lower extremity, and

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Review of the Consult Report dated revealed the resident had gram negative rod bacteremia, "which may still be a contaminant but cannot rule out the possibility of bacteremia from the , right lower extremity advanced age, and

The physical exam revealed a quarter sized with a little black spot on the side and some at the base on the outside of the right leg. The resident was treated with UV Zoysn, an

In a phone interview on at approximately 10:55 AM, the director of nursing (DON) stated the resident would open the dressing and pick at the and put the dressing back on. The resident did not completely remove the dressing. She said "we told her not to". She also stated the HHC nurse provided the care to the resident. The resident went to meals and sat outside most of the day and smoked. She was and the physician was aware. She would urinate on herself, and she would wear briefs. She needed reminders and cueing. She did not want to go to her apartment. The HHC nurse would bring the resident into the nursing office to change her dressing. She would take her to her to the nursing office, wherever the resident wanted to go to change the dressing. She said she was in the office at times when the dressing was changed.

In a phone interview on at approximately 11 AM, the staff nurse/shift coordinator stated the HHC nurse provided the care to the resident. He also stated the resident would pick and scratch at the when the dressing was on. The resident would go to the dining meals and then sat outside during the day and would smoke. The resident had to be cued to go to her incontinence care. He said he observed the HCC nurse taking a culture about 2-3 weeks ago. He said he never observed the dressing change. The wounds were healing slowly and she was frequently . The physician told her to briefs. She did not want to get up from outside and go to She went to meals and then went outside to smoke during the day. He said it was a struggle to coach her to go to her be changed because she often refused to go to her He said they would try to redirect her, and it would take encouraging to go to her be changed.

Review of facility notes dated (no year) revealed the resident was alert with

There was no documentation to review that indicated the HHC agency or healthcare provider was notified that the resident was picking and or scratching the when the dressing was

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on, and compromised the integrity of the dressing, enabling insects to enter the

Resident #18's record review revealed an 1823 dated and updated on with diagnoses of and Parkinson's

Review of facility note dated at 5:20 PM revealed the resident was observed sitting on floor in his apartment with a hematoma noted to back of head. The resident was sent to hospital for evaluation and treatment. There was no documentation the physician was notified or the date of return from the hospital was noted.

Review of facility note dated on indicated the resident called the family member on the phone and was heard telling the family member that he wanted to get out of the community or he would kill himself. The staff was instructed to keep him in the common area and to be aware of his whereabouts and his activities and do frequent There was no documentation that physician was notified of resident's comments.

In an interview with the administrator on at approximately 5 PM, she said she was not aware the physician was not notified.

3. The administrator did not ensure residents who were at risk of elopement had ID on their person that met the requirement.

Record review for resident #23 revealed that on , it was determined she was an Elopement Risk. The facility's elopement policy and procedure noted an elopement was when a resident left the building without following the facility's policy. Which was signing out each time they left the building. Record review revealed that the health care provider noted on that she had a diagnosis of

An incident report noted on at 3:40 PM indicated staff was walking to bus stop. The resident was seen by the Auto Zone store walking in the rain.

During an interview with the dishwasher on at approximately 1:25 PM, he stated when he left work and walked to catch the bus towards the mall that was across the street, he stated it was pouring rain. He stated he heard someone say "hey", he looked over while walking and observed resident #23 by the Auto Zone. He told the resident it was raining and ask her where was she going. She told him she was going home. He told her, "OK, lets go back home." He stated he walked the resident all the way back to the facility to a staff member. He stated resident #23 was

Resident #23 was observed on at approximately 12 PM and did not have elopement

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ID on her person that met the regulatory requirements.

In an interview with the Memory Care director on [redacted] at approximately 12 PM revealed the residents #17, #19, #20, #21, #22, #24 and #25, who resided in the Memory Care Unit (MCU), were identified as at risk of elopement. She stated their elopement IDs were checked at every meal and documented on the meal roster form.

Observation in the MCU on [redacted] at approximately 12:05 PM revealed the elopement IDs for residents #17, #19, #20, #21, #22, #24 and #25 did not include their name, the facility's name, address, and telephone number.

In an interview on [redacted] at approximately 5 PM, the administrator said she was not aware the IDs of residents at risk of elopement did not have the required information. She also stated the residents' IDs were checked every morning in the MCU.

4. The administrator failed to ensure 1 of 5 sampled staff had a statement from the healthcare provider that indicated she was free from all communicable [redacted] (D).

Review of personnel files revealed Staff B, date of hire [redacted] did not have documentation of freedom from all communicable [redacted] signed by the healthcare provided, within 30 days of hire.

In an interview on [redacted] at approximately 7:30 PM, the administrator stated she was not aware staff D did not have a freedom from all communicable [redacted] statement signed by the healthcare provider.

5. Failed to ensure Assisted Living Health Assessment Forms (1823) were completed for 1 of 25 sampled residents who had a change in condition (#18).

Review of the facility note dated [redacted] at 5:20 PM revealed the resident was observed sitting on floor in his apartment with a hematoma to back of head. The resident was sent to hospital for evaluation and treatment. There was no documentation that indicated a new 1823 was completed after the resident had a significant change.

In an interview on [redacted] at approximately 5 PM, the administrator said she was not aware the physician was not notified.

6. The administrator failed to ensure the contract contained the required information regarding rights, duties and [redacted] of residents for 1 of 25 sampled residents (#2).

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Resident record review including contracts for residents #2 revealed that his contract did not include a statement to inform the residents or responsible party that all residents must be assessed upon admission and every 3 years thereafter, or after a significant change, whichever comes first and the facility's policies and procedures related to a properly executed DH form 1896, .

During an interview on at approximately 1 PM, the administrator stated the contract did not include the above information.

7. The administrator failed to ensure adverse incident reports were completed when law enforcement conducted an investigation for 3 of 25 sampled residents (#3, 17 & 23).

Record review for resident #23 revealed that on it was determined she was an Elopement Risk. The facility's elopement policy and procedure noted an elopement was when a resident left the building without following the facility's policy, which was signing out each time they left the building. Record review revealed that the health care provider noted on that she had a diagnosis of .

An incident report noted on at 3:40 PM that the staff was walking to bus stop after work and saw the resident by the Auto Zone store, walking in the rain. The resident told her she was going home.

During an interview with the dishwasher on at approximately 1:25 PM, he stated when he was leaving work and was walking to catch the bus towards the mall that was across the street, it was pouring rain. He stated he heard someone say "hey". He looked over while walking and saw resident #23 by the Auto Zone store. He said he told the resident it was raining and ask her where was she going. She told him she was going home. He told he, "OK, lets go back home." He stated he walked the resident all the way back to the facility and gave her to a staff member. He stated resident #23 was .

Reviewed on a copy of the Police Report from Altamonte Springs #2014E1000349 dated at 7:32 PM for resident #17. The Police Department investigated an incident with resident #4 that took place when the resident tried to choke a staff member with a dog leash.

Resident Record Review and review of the Facility Adverse Incident Report Log conducted on at approximately 10 AM for resident #3 revealed that the resident eloped from the facility on and on . An Adverse Incident report was not filed with the Agency

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for Health Care Adminstration for these two events.

During an interview with the administrator on [redacted] at approximately 3:30 PM, she stated an Adverse Incident report were not completed.

Class II

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on record review and interview, the facility failed to ensure 1 of 6 sampled staff had documentation of freedom from all communicable [redacted] statement from the healthcare provider (D).

Findings:

Review of personnel files revealed staff D, date of hire [redacted], did not have documentation of freedom from all communicable [redacted] signed by the healthcare provider, within 30 days of hire.

In an interview with the administrator on [redacted] at approximately 7:30 PM, she said she was not aware staff D did not have a freedom from all communicable [redacted] statement signed by the healthcare provider.

Class III

0167-Resident Contracts 58A-5.025 FAC

Based on contract review and interview, the facility failed to ensure that each resident contract contained the rights, duties and [redacted] of residents, other than those specified in the Resident Bill of Rights for 1 of 2 sampled residents contracts reviewed (#2).

Findings:

Resident record review including contracts for residents #2 revealed that his contract did not include a statement to inform the residents or responsible party that all residents must be assessed upon admission and every 3 years thereafter, or after a significant change, whichever comes first and the facility's policies and procedures related to a properly executed DH form 1896, [redacted]

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During an interview with the administrator she stated on at approximately 1 PM, she said the contract did not include the above information.

Class

Z821-Reporting Requirements; Electronic Submission 59A-35.110, FAC

Based on record review, Adverse Incident Reports and interview, the facility failed to submitted a Adverse Incident report when 3 of 25 residents eloped from the facility (#3, 17 & 23).

Findings:

1. Record review for resident #23 revealed that on , it was determined she was an Elopement Risk.

The facility's elopement policy and procedure noted an elopement was when a resident left the building without following the facility's policy, which was signing out each time they left the building. Further record review revealed that the health Care provider noted on that she had a diagnosis of

An incident report noted on at 3:40 PM that the staff was walking to bus stop. The resident was seen by the Auto Zone store walking in the rain. She said she was going home.

During an interview with the dishwasher on at approximately 1:25 PM, he stated when he left work and walked to catch the bus towards the mall that was across the street, it was pouring rain and he heard someone say "Hey". He said he saw resident #23 by the Auto Zone store. He said he told the resident it was raining and asked her where was she going. She told him she was going home. He told her, "OK, let's go back home." He stated he walked the resident all the way back to the facility and gave her to a staff member. He stated esident #23 was

During an interview with the administrator on at approximately 3:30 PM, she stated an Adverse Incident report was not completed because, she was not aware that the resident had left the facility alone. She thought that the staff was behind her the entire time when she walked away.

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2. On a copy of Police Report from Altamonte Springs #2014E1000349 on at 7:32 PM for resident #17 was reviewed. The Police Department dated regarding an incident with resident #4 that took place at 7:30 PM. "Staff member was walking in the parking lot with resident #4 and his dog. Staff turned her back to the resident to say good night to another staff who was passing. Staff felt the leash from the dog collar around her neck. Other staff member turned to assist her and resident #17 ran off up Orange Avenue. Other staff ran after resident while staff that was strangled ran into the facility to get help from two other staff. Staff ran after the resident and attempted to calm him. (Resident #4) was calling the staff and would not allow any of them to touch him. (Resident #17) threw a rock at the staff."

3. Resident record review and review of the Facility Adverse Incident Report Log for resident #3 revealed the resident eloped from the facility on and on . An Adverse Incident report was not filed with The Agency for either event.

During an interview with the administrator on at approximately 3:30 PM, she stated Adverse Incident reports were not completed.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Grand Villa Of Altamonte Springs
433 Orange Drive
Altamonte Springs, FL 32701
Attention: Maryann Howell, Administrator

Dear Ams. Howell:

This letter reports the findings of a biennial re-licensure survey conducted on ... and , by representatives of the Agency for Health Care Administration (Agency). Attached 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 **five business days** of receipt of this hand delivered report.

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

1) A0010 - Admissions - Continued Residency Class II
Your Assisted Living facility failed to ensure that residents admitted to your facility continued to be appropriate for continued residency when a resident was a "AT risk for elopement".

2) A0025 - Resident Care - CLASS I
The Assisted Living facility failed to provide adequate supervision to residents who were at risk for elopement. Failed to inform the Home Health Care agency when a resident was picking and scratching at a ...] with a dressing in place. also failed to inform and document "That the health care provider" was informed of significant changes

3) A0077 - Staffing Standards - Administrators Class II
The Assisted Living facility's Administrator failed to provide adequate oversight of the facility and the facility staff by failing to ensure the facility's elopement policy was followed, failed to make sure residents that were identified at risk for elopement maintained identification on their person at all times. Ensure outside agencies providing care to your residents were kept ... of issues concerning your residents when providing ...] care.

Your facility must comply with the following:

1) Your facility must re-assess and evaluate residents for the appropriateness of continued placement in your assisted living facility. All disciplines should be present when the continued residency of a resident is discussed. This will allow all who work with the resident

can give pertinent information about the resident. Also, complete updated health assessments to document continued appropriateness for residency. This must be completed within **5 calendar days** from the date of this letter.

2) The Assisted Living Facility should be in constant communication with all outside agency's that enter the facility to provide care to the residents of the Assisted Living facility. This communication between the outside agency and the facility should be documented and available for review by the agency upon request. The documentation may be through the use of a log and/or notes. This will enable the facility have documentation of communication with outside agencies and any concerns or issues the facility will need to convey to the outside agencies. This must be completed within **5 calendar days** from the date of this letter.

3) There should be a care plan put in place to address issues or concerns that may arise when the outside agency is not at the facility and may not be there for a couple of days. The care plan should be documented and available for review by the agency upon request. The facility has the ultimate responsibility to ensure their residents are receiving adequate care. This must be completed within **5 calendar days** from the date of this letter.

4) The facility need to retrain all staff on its elopement policy and procedures. This will enable the staff to readily recognize when a resident is presenting risks for elopement. Also they will be able identity when a resident that has been identified as an elopement risk has the proper identification on their person at all times. This must be completed with **5 calendar days** from the date of this letter.

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 ..... Lorraine Henry, Assisted Living Supervisor Orlando, at (407) 420-2534.

Sincerely,

Lorraine Henry
Health Facility Evaluator Supervisor

LH/be

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

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400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone (407) 420-2502; Fax (407) 245-0998

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Grand Villa Of Altamonte Springs
433 Orange Drive
Altamonte Springs, FL 32701

RE: Biennial relicensure

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 14-16, 2014 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 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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