STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942983	**04/28/2019**
NAME OF PROVIDER OR SUPPLIER **AIDEN SPRINGS**	STREET ADDRESS, CITY, STATE, ZIP CODE **5520 HOWELL BRANCH ROAD** **WINTER PARK, FL 32792**	

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

0000 - Initial Comments

A Complaint Investigation #2019001358 was conducted at Aiden Springs Assisted Living Facility, License #8419 on , , and . The facility had deficiencies at the time of the investigation.

0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on resident record review and interview, the facility failed to obtain an AHCA Form 1823 Health Assessment dated by the healthcare provider as required for 1 of 3 sampled residents (#1).

Findings:

Resident 1's record revealed a date of admission as . The 1823 Health Assessment found was not dated by the healthcare provider (Photographic evidence obtained).

On at 3 PM, an interview with the Administrator confirmed the finding.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on resident record review, facility's reports, Seminole County police report and interview, the facility failed to provide appropriate and adequate supervision to 1 of 3 sampled residents (#1) with .

Findings:

Resident #1's record revealed admission date . A newer 1823 Health Assessment provided but not dated by the healthcare provider documented that resident has but indicated not an elopement risk.

Facility documentation dated at 2:34 AM, that resident #1 was returned to the facility by Seminole County Sheriff deputy after eloping from the side exit door near the hallway sometime around midnight.

A telephone interview on at 9:45 AM with caregiver A stated that she was completing her job

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duties of mopping the floor and washing clothes. She last checked all exit doors at 9 PM, which is when visiting hours end and last cigarettes for residents to smoke. She was not aware that resident #1 left the facility until law enforcement returned him to the facility.

An interview with resident #1 on at 10 AM stated that his roommate told him that his ex-wife was waiting for him outside in the parking lot. He went out the side exit door in the hallway because the staff normally lock all doors at 9pm. He did not see her car outside in the parking lot, so he decided to walk up the street and got of his location.

On at 10:30 AM, a family interview with ex-wife who confirmed that resident #1 told her that his roommate told him that she was waiting for him and that was the reason he left. Family member stated that he never did this before and and follow directions.

On at 10:37 AM, an interview with the Administrator who stated he completed internal investigation few hours later approximately at 8 AM on as well sending resident #1 to the healthcare provider to be checked for any additional health concerns. Administrator submitted an adverse incident report to the Agency for Health Care Administration (AHCA) on .

On at 1 PM, review of the police report confirmed the Seminole county deputy was on at 1:45 AM that an elderly man was found on the streets about 1 mile from the assisted living facility freezing , , and disoriented. The resident was medically cleared by the nearby Seminole County Fire Rescue and returned to the assisted living facility by a sheriff deputy at 2:30 AM.

The staff that was on duty of the time the resident left the facility was not aware that the resident was not at the facility until law enforcement brought the resident to the facility. According to the staff she checked the doors at 9:00 PM and she was awake mopping floors and during laundry. However, she does not state when was the last time she check the residents including resident #1.

On at 9:30 AM, a second telephone exit interview with the Administrator confirmed the findings.

Photographic Evidence Obtained

Class III