Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968448	A. BUILDING: _____ B. WING _____	08/27/2026

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE
SERENADES BY	-WEST ORANGE	720 ROPER ROAD WINTER GARDEN, FL 34787

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ZZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	ZZ821		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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ZZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	ZZ821		

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ZZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Residential Mental Health Providers: Crisis stabilization units, short-term residential treatment facilities, residential treatment facilities, and residential treatment centers for children and adolescents shall submit incidents as required by Section 394.907, F.S., and rules promulgated thereunder to the Agency within 1 business day of occurrence on Residential Mental Health Provider Incident Report, AHCA Form 3180-5008OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-18470, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal 6. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 7. For the purposes of this rule, the following applies for submitting adverse incident reports:	ZZ821		

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ZZ821	Continued From page 3 a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on the facility reviews and interviews, the facility failed to electronically submit to the agency a preliminary report within 1 business day of incident and a full report within 15 days of the incident for 1 of 5 sampled residents (#3). Findings:	ZZ821		

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ZZ821	Continued From page 4 Review of Resident #3's 1823 health assessment indicated unspecified , unspecified myopathies, and identified as a risk. A facility note on at 2:30 PM, home health left lower attached with stitches. A facility note on at 2:10 PM, Bliss care visited resident for care team. A facility note on at 2:50 PM, resident returned from hospital. A facility note on at 8:32 AM, received call from hospital. Nurse stated the resident received 8 to and care instructions. A facility note on at 9:20 PM, at 2030 (8:20 PM) nurse called to Brio community dayroom. Upon entering dayroom resident was observed on the floor. Resident attempted to stand and to the ground. Resident had a proxy. 4 - 5-inch open across the left front area. 911 called and resident transported to hospital. On at 3:55 PM, LPN E stated he was the nurse who entered the dayroom and observed Resident #3 on the floor. When attempting to help her up she , resulting in the to her left. On at 9:40 AM, the Wellness Director stated the facility did not do an adverse because the resident did not anything and returned the next day with stitches due to the . Further stating, the Administrator submits the incident reports and the regional	ZZ821		

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ZZ821	Continued From page 5 nurse advised they did not need to report. Unclassified	ZZ821		
A 000	Initial Comments Two (2) complaint investigations #2026010684, #2026011633, and generator monitoring was on - at Serenades by - West Orange. The facility had deficiencies at the time of the survey.	A 000		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the	A 008		

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A 008	Continued From page 6 appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided	A 008		

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A 008	Continued From page 7 that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , , , require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or , , services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication,	A 008		

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A 008	Continued From page 8 6. Whether the individual has signs or symptoms of , , , , or any other communicable , which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided.	A 008		

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A 008	Continued From page 9 (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, . . , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish . , to be administered in the case of or , . (f) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain an AHCA Form, 1823	A 008		

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A 008	Continued From page 10 Health Assessment that had the correct information completed by the healthcare provider as required for 1 of 9 sampled resident (#4). Findings: Review of Resident 4's current 1823 health assessment indicated a history of and was not identified as an elopement. Her admission 1823 indicated secured unit for safety, , exit seeking, and identified as an elopement risk. The 1823 also identified the resident as an elopement risk. On at 4:55 PM, LPN D stated the resident had an ID on before leaving for the hospital. On at 9:40 AM, the Wellness Director stated after reviewing the current 1823 she will need to get an updated form. Adding, the resident returned from rehab with the 1823 and they checked the box. On at 5:35 PM, the Wellness Director and Business Office Manager confirmed the findings. (photographic evidence obtained)	A 008		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A	A 010		

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A 010	Continued From page 11 determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical	A 010		

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A 010	Continued From page 12 assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment,	A 010		

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A 010	Continued From page 13 or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency;	A 010		

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	AL11968448	A. BUILDING: _____ B. WING _____	08/27/2026

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A 010	Continued From page 14 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on resident reviews and interviews, the facility failed to obtain a new AHCA Form, 1823 Health Assessment completed by the healthcare provider for continued residency after a significant change for 4 of 9 sampled residents (#3, #5, #6, #7) as required in an assisted living facility (ALF). Findings: Review of Resident #3's 1823 health assessment indicated n/a (non-applicable) for nursing/treatment/ , , service requirements. A facility note on at 2:30 PM, home health	A 010		

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A 010	Continued From page 15 LLL (left lower) . A facility note on at 2:10 PM, Bliss care visited resident for care team. A facility note on at 8:28 AM, Celestial visit training 25 . A facility note on at 8:42 AM, Celestial . On at 4:55 PM, LPN D stated the resident has been receiving for strengthening for a while now. Further stating, she's getting home health now due to the on her . On at 9:40 AM, the Wellness Director stated the resident is receiving home health services for the and was getting . Further stating, she did not know she needed a new 1823 for Resident #3's change of condition. 2. Review of Resident #5's record revealed an admission date of . Review of the 1823 revealed the resident was not identified as a risk. Her medical history included mild and . Her Activities of Daily Living (ADL's) revealed she was independent with ambulating and transferring. Review of Resident #5's post risk assessments dated , , and revealed a score of 10. The forms revealed a score of 10 or more indicated a high risk for . Review of a facility note, dated at 6:49 PM, revealed the resident was observed ambulating when she tripped on the carpet and forward, striking her on the floor.	A 010		

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A 010	Continued From page 16 Review of a facility note, dated at 10:30 AM, revealed at 2:20 AM, the Resident was noted lying on the floor next to her bed wrapped up in her comforter. Review of a facility note, dated at 11:57 PM, revealed at 11:15 PM, the resident was observed on the floor in her room sitting next to her bed. Resident complained of a little , in the left side of her . During an interview on at 10:36 AM, the Wellness Director said Resident #5 was considered a risk because she has had three . 3. Review of Resident #6's record revealed an admission date of . Review of 1823 revealed the Resident was identified as a risk. Her medical history included , and she was independent with all ADL's During an interview on at 10:42 AM, the findings of the 1823 were discussed with the Wellness Director. The Wellness Director said she provides Resident #6 with standby shower assist for safety. The Wellness Director added she does it out of precaution. The Wellness Director said she has not spoken to Resident #6's healthcare provider about the resident needing stand by shower assist. The Wellness Director said sometimes Resident # 6 needs to be prompted to take a shower. During an interview on at 11:40 AM, Unlicensed Caregiver C said she provides stand by shower assist for Resident #6. The Unlicensed Caregiver said the resident showers herself if she is shown what to do. Unlicensed Caregiver C	A 010		

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A 010	Continued From page 17	A 010		

said, Resident #6 needed to be reminded to have a shower, and she will assist with ˬ if needed. Unlicensed Caregiver C said Resident #6 cannot be left by herself in the shower, and she would stand close to the outside of the bathroom door just in case the resident or slips.

During an interview on at 11:49 AM, Resident #6's family said the resident shower items need to be prepared.

4. Review of Resident #7's record revealed an admission date of . Review of the 1823 revealed the resident was not identified as a risk. Her medical history included and her ADL's revealed she was independent with ambulation and transferring.

Review of Resident #7's admission risk assessment and post risk assessments dated , and revealed a score of 10. The forms revealed a score of 10 or more indicated a high risk for .

Review of a facility note dated at 8:18 PM, revealed at 7:40 PM, the staff found the Resident lying on her at the entrance way of her bedroom in front of her closet. The Resident said that she got ˬ, her ˬ became weak, and she backwards hitting her .

Review of a facility note dated at 2:39 PM, revealed Resident #7 was walking in the courtyard, when she slipped onto her .

Review of a facility note dated at 2:30 PM, revealed the Resident experienced an unwitnessed while leaving the dining table.

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A 010	Continued From page 18 Review of a facility note, dated at 1:31 PM, revealed at 7:32 AM, Resident #7 was found during the morning rounds lying on the floor in supine position next to her bed. During an interview on at 11:11 AM, the Wellness Director said Resident #7 had more than one and was considered a risk. During an interview on at 2:48 PM, Unlicensed Caregiver F said Resident #7 is considered a risk. The Unlicensed Caregiver added Resident #7 stumbled a lot while walking and tends to lose her balance. During an interview on at 2:53 PM, Caregiver H said Resident #7 had a balance issue and was very shaky when she walked. On at 5:35 PM, the Wellness Director and Business Office Manager confirmed the findings. (photographic evidence obtained) Class III	A 010		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If	A 025		

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A 025	Continued From page 19 an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making . , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as	A 025		

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A 025	Continued From page 20 needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide adequate supervision to 1 of 1 sampled resident (#2) who eloped from the secured memory care unit by maintaining a general awareness of the resident whereabouts and emotional general well-being; failed to provide adequate supervision in 2 of 9 sampled residents (#5, #7) to ensure safety through proactive measures to minimize the potential for with injuries, and failed to maintain updated written records of any significant changes for service plans in 2 of 9 sampled residents (#5, #7). Findings: 1. Review of Resident #2's record revealed a facility admission on . A 1823 health assessment indicated with behavioral disturbance and identified as an elopement risk. Review of an incident report dated indicated an event that is reported to law enforcement and resident elopement. At approximately 4:15 AM, the resident forcefully pushed through the secured exit doors and exited the memory care community. A facility note on at 9:34 AM, resident was admitted to hospital with a diagnosis of / disorientation.	A 025		

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A 025	Continued From page 21 A facility note on at 4:15 AM, resident forcefully pushed through the secured exit doors and exited the memory care community. Wellness Associate C attempted to prevent the resident from leaving by redirecting him into the building. During the intervention, resident overpowered the associate forcefully pushing her to the ground before continuing to the parking lot. Resident continued through the parking lot towards Summit Assisted Living. Wellness Associate C followed resident in her vehicle in an effort to maintain visual contact, however, the resident briefly moved out of sight after attempting to conceal himself within the Summit parking lot. On at 11:30 AM, Wellness Associate C stated Resident #2 just got up saying he wanted to leave, pushed her down and went out. She stated she was right there by the door when the alarm sounded. She went out the door behind the resident and saw him walking to Summit. She said after he walked towards Summitt she ran inside to get her keys. Adding, she could not follow on because there was no one inside with the residents. She radioed for another staff and was inside for 2 -3 minutes waiting for them to come. Wellness Associate C stated she went outside through the broken door and did not see the resident. She called the Wellness Director who called the police and the Administrator. The facility's Elopement Policy states designated team members will canvas the local area on as well as a further in vehicles. A facility note on at 7:42 PM,	A 025		

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A 025	Continued From page 22	A 025		

approximately 4 PM, staff brought the resident to nurse station to assist with resident who was exit seeking on unit. Resident was voicing that his son was coming to pick him up and he needed to go outside to meet him. The resident's son called , writer spoke with him about his dad exit seeking and asked if he could speak with him. While on the unit, Nurse had to redirect resident several times from attempting to exit unit. PRN was given, kept resident occupied until bedtime.

On at 4:55 PM, LPN D stated during her shift (3 -11) the staff would bring Resident #2 to her in her office to help with keeping him calm and give him snacks. She said he would always go to the exit door and was always exiting seeking.

A facility note on at 10:32 AM, resident attempted to exit community and was redirected to TV room. PRN administered and guard checked. One on One sitter in place by facility staff.

A facility note on at 5:02 PM, resident attempted to exit neighborhood voicing he need to go be with his wife, was easily directed. The resident attend activities with his bag pack with some of his personal belongings. Facility staff were assigned to sit with the resident. New guard was placed on .

A facility note on at 7:30 PM, resident was noted exhibiting exit seeking behaviors with a bag with his belongings in it. Resident states he wants to go home.

A facility notes on at 1:03 PM, resident was noted exhibiting exit seeking behaviors with a

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A 025	Continued From page 23 bag with his belongings in it. Repeatedly stating desires to leave to be with his wife. A facility notes on at 7:41 PM, resident was observed with belongings packed in a bag, stating "I'm leaving to be with my wife". On at 3:30 PM, the Wellness Director stated the resident exited through Brio. Further stating, he went out the exit door (near the dining room and common area). Adding, the door will open after 10 -12 sec. She said the 2nd exit door automatically locks as soon as it detects the guard. She said the staff attempted to stop the resident from exiting the building, but he pushed her down and broke the door to get out. On at 3:55 PM, LPN E stated the residents cannot get but when the families visit, they can leave with them. On at 10:20 AM, the Wellness Director stated Wellness Associate C was changing another resident in the washroom when Resident #2 eloped. Adding, during the overnight shift there is 1 caregiver in each community and a float who assists as needed. She stated Wellness Associate C should have radioed for the float before leaving the floor. On at 3:29 PM, the POA stated Resident #2 had eloped more than once from the facility. Adding, she was told she needed to get a sitter. She said the facility knew of Resident #2's behaviors prior to accepting him for admission. Further stating, someone from the facility visited the hospital while he was for his behavioral disturbance pulling a gun on the POA and was aware of his diagnosis of , .	A 025		

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A 025	Continued From page 24 On at 3:55 PM, the Wellness Director stated the facility did everything possible to keep Resident #2 from eloping and added one on one staff sitters after he started exit seeking. The overnight staff knew once he got up and started walking around, he was not to be left alone. Further stating, the Administrator told the staff to call for the float when needing to leave the floor due to Resident #2 constantly attempting to leave. 3. Review of Resident #5's record revealed an admission date of . Review of the 1823 revealed the resident was not identified as a risk. Her medical history included mild and . Review of Resident #5's post risk assessments dated , , and revealed a score of 10. The forms revealed a score of 10 or more indicated a high risk for . Review of a facility note, dated at 6:49 PM, revealed the resident was observed ambulating when she tripped on the carpet and forward, striking her on the floor. She was noted to be from the right side of her and had slight to the center of her forehead. The Resident was transported by Emergency Medical Services ( ) to a hospital. During an interview on at 10:33 AM, the Wellness Director said on Resident #5 was walking in the hallway and had sneakers that had too much grip which caused her to . The Resident was sent to the hospital for evaluation. The Wellness Director said Resident #5 sustained a on her right and a small	A 025		

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A 025	Continued From page 25 Review of a facility note, dated at 8:19 AM, revealed the Resident remained at the hospital. The Resident featured her right and had a small - Review of a facility note, dated at 9:34 PM, revealed the resident returned to the community. The Resident was noted with a scab to the right side of her . There was on her upper , forehead, right and right side of her . Review of a facility note, dated at 10:17 AM, revealed the Resident's family brought in a rolling walker and requested for the resident to use it to prevent future accidents. The Resident refused to use it. Review of a facility note, dated at 10:30 AM, revealed at 2:20 AM, the Resident was noted lying on the floor next to her bed wrapped up in her comforter. The Resident complained of , and was sent to the hospital for further evaluation. During an interview on at 10:36 AM, the Wellness Director said on Caregiver L called to inform her that Resident #5 was found on the floor and was transferred to the hospital. The Wellness Director said the resident was considered to have had . The Wellness Director added that Resident #5 was considered a risk because she has had three . During an interview on at 4:15 PM, Caregiver L said on she was doing her rounds at approximately 11:30 PM, when she found Resident #5 on her bedroom floor. The Caregiver said she learned from the Resident that	A 025		

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A 025	Continued From page 26 she slipped off the bed with her sheet unto the floor. The Caregiver said Resident #5 complained of discomfort on the right side of her , . were called, and the resident was taken to the hospital. Review of a facility note, dated at 10:45 AM, revealed the resident returned from the hospital. Review of a facility note, dated at 11:57 PM, revealed at 11:15 PM, the resident was observed on the floor in her room sitting next to her bed. Resident could not verbalize how she . Resident complained of a little , in the left side of her . Resident had on shoes and her walker was standing up right in front of the door. During an interview on at 4:34 PM, Licensed Practical Nurse (LPN) D, said on she learned from Caregiver L that Resident #5 was on the floor. The LPN said the Resident slid off her bed and complained of a little , on her left side of her . The LPN said this incident was classified as a . During an interview on at 4:20 PM, Caregiver L said on Resident #5 slid off her bed unto her bedroom floor. The Caregiver said the resident was assessed by LPN D and assisted to bed. The Caregiver said that Resident #5 does not like to stay in bed and likes to move around. The Caregiver added that she constantly needs to supervise the Resident. Review of Resident #5's individual service plan revealed no interventions after her and .	A 025		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 27 During an interview on at 3:10 PM, the findings were discussed with the Wellness Director. The Wellness Director said she did not update the service plan for Resident #5's and . The Wellness Director said she only wrote the note on the bed being lowered because it was the common denominator of the Resident sliding out of the bed. The Wellness Director said the Resident's bed was high, and she was having a hard time getting in and out of it. 4. Review of Resident #7's record revealed an admission date of . Review of the 1823 revealed the resident was not identified as a risk. Her medical history included . Review of Resident #7's admission risk assessment and post risk assessments dated , and revealed a score of 10. The forms revealed a score of 10 or more indicated a high risk for . Review of a facility note dated at 8:18 PM, revealed at 7:40 PM, the staff found the Resident lying on her at the entrance way of her bedroom in front of her closet. The Resident said that she got , her became weak, and she backwards hitting her . The Resident was transported to the hospital. During an interview on at 4:40 PM, LPN D said she recalled one of the but does not remember the month. The LPN said she sent Resident #7 out to the hospital after she was observed on the floor in her room, by the closet. Review of a facility note dated at 2:39 PM, revealed Resident #7 was walking in the courtyard, when she slipped onto her .	A 025		

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A 025	Continued From page 28 During an interview on at 11:03 AM, the Wellness Director said Resident #7 was walking in the courtyard and walked over to the mulch and she to the ground. Review of a facility note dated at 2:30 PM, revealed the Resident experienced an unwitnessed while leaving the dining table. Staff observed the Resident's bump against a walker causing her to lose her balance and backwards hitting the of her . was called and the resident was transferred to the hospital. During an interview on at 2:48 PM, Unlicensed Caregiver F, said the resident was getting up from lunch in the dining area, tripped over another resident's walker, and to the floor. The Unlicensed Caregiver said Resident #7 is considered a risk; she stumbles a lot while walking and tends to lose her balance. During an interview on at 11:05 AM, the Wellness Director said Resident #7 was trying to maneuver a walker that was in the pathway and she tripped over it and . The Wellness Director said the Resident hit the of her and was sent out to the hospital. Review of a facility note, dated at 1:31 PM, revealed at 7:32 AM, Resident #7 was found during the morning rounds lying on the floor in supine position next to her bed. Resident stated she tripped over the area rug on the floor next to her bed. She was transported to the hospital. During an interview on at 2:45 PM, Unlicensed Caregiver F said on , she heard Resident #7 calling for help from her room.	A 025		

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A 025	Continued From page 29 Unlicensed Caregiver F said she found the resident lying on her on her bedroom floor. The Unlicensed Caregiver said there was a carpet folded up next to the resident. Unlicensed Caregiver F said the nurse was notified and the resident was sent to the hospital. During an interview on at 11:07 AM, the Wellness Director said on she learned from Unlicensed Caregiver F that Resident #7 was lying on the floor beside her bed complaining of . The Wellness Director said were called and the resident was transferred to the hospital. The Wellness Director added, Resident #7 sustained a to the right . Review of a facility note, dated at 3:52 PM, revealed the Resident broke her right and would be having surgery. During an interview on at 2:53 PM, Caregiver H, said that Resident #7 had a balance issue and was very shaky when she walked. The Caregiver added that the Resident does not use a walker, and she is not receiving , , , . During an interview on at 11:11 AM, the Wellness Director said Resident #7 had more than one and was considered a risk. The Wellness Director added the Resident was not receiving , , , . Review of Resident #7's individual service plan revealed no interventions after her , , , or . During an interview on at 3:12 PM, the findings were discussed with the Wellness Director. The Wellness Director said there was a	A 025		

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A 025	Continued From page 30 more updated service plan. During an interview on at 3:20 PM, the Wellness Director said she was unable to find the documentation of the updated service plan with the interventions for Resident #7. Neither Record contained a negotiated risk agreement. During an interview on at 3:11 PM, the findings were discussed with the Wellness Director. The Wellness director confirmed the findings and added that she did not know it was her responsibility to have a negotiated risk agreement completed. Review of Resident #5's individual service plan revealed it was signed only by the Administrator and the Wellness Director. The document was not signed by the Resident's family. Review of Resident #7's individual service plan revealed it was signed only by the Administrator and the Wellness Director. The document was not signed by the Resident's family. During an interview on at 5:32 PM, findings were discussed with the Wellness Director. The Wellness Director said the Administrator informed her the service plans were emailed to the families. The Wellness Director said that she does not see documentation that the service plans were signed by the Resident's family. Review of the facility's risk assessment policy with a revision date on , revealed the	A 025		

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A 025	Continued From page 31 following. If a resident is determined to be at a high risk for , an action plan that includes specific interventions will be developed by the Wellness Director and included in the resident service or wellness plan. interventions will be included in the resident's wellness plan and communicated to the community's interdisciplinary care team by the Wellness Director. When the resident , the resident's wellness plan is reviewed and revised to include specific interventions based on the resident's status and needs. Review of the facility's post procedures policy with a revision date of revealed the following. Any resident experiencing a will receive the appropriate care and interventions necessary immediately after the . The Wellness Director and the Executive Director will consult on proper follow-up related to resident service plan changes, risk assessment and follow-up, and negotiated risk agreement. Review of both Resident records did not contain documentation of interventions on the individual service plan for all the identified . Neither record contained documentation of a negotiated risk agreement. On at 5:35 PM, the Wellness Director and Business Office Manager confirmed the findings. (photographic evidence obtained) Class II	A 025		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures	A 030		

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A 030	Continued From page 32 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities;	A 030		

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A 030	Continued From page 33	A 030		

2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and
. ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .

(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.

(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.

429.28 Resident bill of rights.-

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a

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A 030	Continued From page 34 facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including	A 030		

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A 030	Continued From page 35	A 030		

the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff

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A 030	Continued From page 36 of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of	A 030		

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A 030	Continued From page 37 residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide a 45 days' notice of relocation or termination of residency in 1 of 2 sampled residents. Findings: Review of Resident #2's record revealed a facility admission date on and a discharge date on . Review of Resident #2's resident agreement states upon less than forty-five (45) days' notice. In addition, Serenades may terminate this Agreement with less than 45 days' notice under the following circumstances: (i) if medical reasons, you are certified by a physician to require an emergency relocation to a facility	A 030		

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A 030	Continued From page 38 providing a more skilled level of care. A facility note on at 11:53 AM, ED (executive director) spoke with case management at Orlando Health. Case Management agreed that the resident is no longer appropriate for residential placement. A facility note on at 9:34 AM, resident was admitted to hospital with a diagnosis of / disorientation. On at 4:55 PM, LPN D stated during her shift (3 -11) the staff would bring Resident #2 to her in her office to help with keeping him calm and give him snacks. She said he would always go to the exit door and was always exiting seeking. On at 3:29 PM, the POA stated the Wellness Director called a family friend to tell them that Resident #2 could not return after the elopement. Further stating, he was and was not allowed into the building. On at 3:55 PM, the Wellness Director stated she called Resident #2's son to tell him that the facility could not keep the resident safe and that they could not take him at this time. Further stating, the Administrator told her to call the family to tell them they could not take him . The Wellness Director stated she went to the hospital to have the social worker to find a place or assist. She said she was not apart in the decision making and no documentation was provided or obtained from the physician. Further stating, the Administrator made the decision not to take him after he eloped. On at 5:35 PM, the Wellness Director	A 030		

Agency for Health Care Administration

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A 030	Continued From page 39 and Business Office Manager confirmed the findings. Class III	A 030		