

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Legacy Pointe at Ucf		STREET ADDRESS, CITY, STATE, ZIP CODE 2120 Hestia Loop Oviedo, FL 32765	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from neglect by not ensuring the staff maintained a secure environment and implemented measures to mitigate the risks to prevent elopement for 1 of 6 residents reviewed for elopement, of a total sample of 6 residents, (#1). These failures contributed to the elopement of resident #1 and placed him at risk for serious injury/impairment/death. While resident #1 was outside the unit unsupervised, there was reasonable likelihood he could have gone up to the roof and fallen off, fallen down the stairs with his walker or been hit by a car. On 9/16/25 at approximately 2:00 PM, the facility failed to prevent a resident with severe cognitive impairment from exiting the facility unsupervised. The facility was unaware of resident #1's whereabouts until he was observed outside on the sidewalk by a maintenance staff member at approximately 2:15 PM and returned to the unit at approximately 2:30 PM. The facility failed to ensure the unit was secured and that resident #1 was adequately supervised to ensure vulnerable residents did not exit the facility without staff knowledge. Review of information provided by the facility revealed a total of 5 residents were identified as at risk for elopement on the first day of survey. The facility's failure to provide adequate supervision and a secure environment contributed to resident #1's elopement and threatened all residents who were at risk of elopement. This failure resulted in Immediate Jeopardy which started on 9/16/25 and was removed on 9/19/25 after verification of the immediate actions implemented by the facility. The scope and severity was decreased to a D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Substandard Quality of Care was identified at F600 and F689. A partial extended survey was conducted on 11/18/25. The noncompliance at F600 was determined to be past noncompliance as of 10/16/25. The census at the start of the survey was 44. Findings: Cross reference F689. Review of the medical record revealed resident #1, an [AGE] year-old male, was admitted to the facility on [DATE]. His diagnoses included unspecified dementia, metabolic encephalopathy, unsteadiness on feet, muscle weakness and other abnormalities of gait and mobility. Review of the Minimum Data Set (MDS) admission assessment with assessment reference date of 9/10/25 revealed resident #1 had a Brief Interview for Mental Status score of 3/15 which indicated he had severe cognitive impairment. The assessment indicated resident #1 used a wander/elopement alarm daily but did not exhibit wandering behavior during the review period. It was noted that resident #1 ambulated with the use of a walker but an evaluation of his ability to go up and down steps was not attempted due to his medical conditions and/or safety concerns. Review of physician orders revealed an order dated 9/03/25 for an electronic wander alert bracelet to be applied to resident #1's wrist. A progress note dated the same day indicated the wander alert bracelet was placed on resident's left wrist. Resident #1's electronic medical record (EMR) contained an elopement risk assessment dated [DATE] which indicated resident #1 was at risk for elopement. Review of the EMR revealed no baseline or comprehensive care plan was developed or initiated to address resident #1's elopement risk prior to his elopement on 9/16/25. On 11/17/25 at 1:28 PM, Maintenance Technician A verified he was part of the maintenance team. He explained he worked all over the facility campus. He recalled on the day (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident #1 eloped, he was returning from the garbage compactor area heading toward the front of the facility in a golf cart. He stated he noticed a resident outside with his walker who appeared out of place. Maintenance Technician A explained he stopped the cart and approached the resident to check on him. He stated he realized the resident may need help and called the Assistant Maintenance Director for assistance. Maintenance Technician A recalled he remained with resident #1 until other staff arrived and then left to return to work. In a phone interview on 11/18/25 at 10:12 AM, the former Director of Nursing (DON) recalled the day resident #1 was found outside the facility. She explained she was notified of resident #1 being outside and went downstairs to meet the staff who went outside to return the resident to the nursing unit. She stated the resident was immediately placed on one-on-one (1:1) observation and an investigation was initiated. She recounted they attempted to re-enact the event and determined resident #1 must have exited through the emergency exit door. She stated the egress door malfunctioned and did not alarm or lock the way it should have. She explained there were contractors working in the unit that day and the work may have affected the door function. On 11/17/25 at 1:36 PM, the Maintenance Director directed surveyors to the stairwell emergency exit door in the nursing unit. The door was noted to have a wander alert sensor, a red screamer alarm and a sticker on the door which indicated it was a 15-second egress door. The Maintenance Director stated the egress door had malfunctioned on 9/16/25 and the door did not lock or alarm when resident #1 exited through the door. He explained the red screamer alarm was battery operated but had not sounded when the door was opened. In a follow-up interview on 11/18/25 at 1:40 PM, the Maintenance Director stated door audits were conducted daily for one week immediately following the event and then moved to weekly. He clarified there were no documented door checks completed prior to the event. The Maintenance Director explained the maintenance department only checked the doors prior to the event if there had been a report of them not working properly. On 11/18/25 at 11:58 AM, the MDS Coordinator reviewed resident #1's comprehensive care plan. She acknowledged that neither a baseline care plan nor a comprehensive care plan had been developed prior to the event to identify the elopement risk or to provide interventions including supervision for the at-risk behavior. The MDS Coordinator was unable to explain why a care plan had not been initiated prior to the event. In a meeting with the Administrator and DON on 11/17/25 at 3:24 PM, the Administrator stated the facility initiated an investigation and corrective measures immediately following the elopement on 9/16/25. He reported the investigation showed resident #1 exited the facility through the second floor Stairwell Emergency Exit door on the nursing unit. He explained that the facility was able to determine the alarm for the 15-second egress door temporarily malfunctioned and the door did not lock or alarm when resident #1 exited. The Administrator clarified the wander alert sensor next to the door was not engaged to work because the door was a delayed egress door and would have been locked if the door functioned properly. The Administrator added that the investigation showed the red screamer alarm was discovered to have been turned to the off position. He explained the red screamer alarm could only be turned off with a key only accessible to maintenance and licensed nursing staff. He verified a staff member had intentionally turned the alarm to the off position, but the facility was unable to determine which employee was responsible. The Administrator acknowledged this created an unsecured environment which enabled resident #1 to exit through the stairwell emergency exit door, descend a flight of stairs and ultimately exit the facility. Review of the facility's policy and procedure for Abuse, Neglect and Exploitation last reviewed on 9/17/25 revealed neglect meant a failure to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress. Review of corrective measures implemented by the facility revealed the following, which were verified by the survey team at the time of the survey: *Resident was returned to the facility on 9/16/25 at 2:30 PM by facility staff and was assessed by former DON upon re-entry into facility with no signs of injury or dehydration noted. *Resident #1 was immediately placed on 1:1 monitoring upon his return on 9/16/25 at 2:30 PM and remained on 1:1 monitoring until his discharge on [DATE]. *On 9/16/25 at approximately 2:45 PM - a census headcount was completed. *On 9/16/25 at 3:09 PM - (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the physician was notified of resident #1 being observed outside. * On 9/16/25 at approximately 4:00 PM - the Assistant Director of Maintenance checked the unit entrance door, alarm and keypad for function. *An Elopement Risk Assessment was completed for resident #1 on 9/16/25 at 4:28 PM by Nursing Supervisor. *A head-to-toe assessment was completed by the nurse on duty on 9/16/25 at 4:45 PM with no injuries or adverse effect noted. Vital signs were within normal limits. *Elopement Risk Assessments for all residents were updated on 9/16/25 by the Nursing Supervisor. *An Elopement Risk Care plan for resident #1 was initiated on 9/16/25 by the MDS Coordinator. *Resident #1's responsible party was contacted on 9/16/25 at 5:26 PM, by the former Director of Nursing. *On 9/16/25 - the former DON/designee(s) and/or MDS Coordinator(s) re-evaluated residents at risk for wandering/elopement using an elopement risk assessment tool. *On 9/16/25 - 100% of residents were re-evaluated for Elopement Risks. The DON or designee began auditing new admissions for elopement risk and ensuring appropriate interventions were in place. *On 9/17/25 - residents affected by the deficient practice had their care plan reviewed and updated by the former DON or designee to reflect current wandering and elopement risk. *On 9/17/25 - the DON or designee began auditing completed MDS's to ensure the care plan reflected needs/concerns identified in the Care Area Assessments. *On 9/17/25 - the policy and procedure for Elopements and Wandering Residents was reviewed. No changes were made. *On 9/16/25 - door check audits were initiated to check functionality and screamer positioning for the unit entrance door, back stairwell exit-door and the kitchen door. Door check audits continued every shift through 10/16/25. *On 9/16/25 - the Administrator and DON began monitoring for exit seeking behavior and elopement risk during daily community rounds and will continue monitoring. *On 9/17/25 - the Interdisciplinary Team (IDT) began to monitor the 24-hour report during morning stand-up meeting for potential elopement risks/exit seeking behavior and will continue to monitor in morning stand-up meetings. *On 9/17/25 - initiated DON/designee to monitor new admissions for accuracy of elopement risk screens and ensure appropriate interventions were in place. *On 9/19/25 - an AD-HOC Quality Assurance Performance Improvement (QAPI) meeting was held with the Administrator, DON, Medical Director and members of the IDT to discuss the event. A Performance Improvement Project (PIP) was implemented to review and interpret all audit findings. *On 10/03/25 - the baseline care plan was revised to include Elopement Care plan for those residents identified as at risk for elopement. *From 9/17/25 through 09/20/25 - Nursing Leadership provided education to all staff regarding abuse, neglect, and exploitation. Education included the Abuse, Neglect, and Exploitation Policy and Procedure and facility reporting protocol.32/32 (100%) nurses educated by 9/22/25.52/52 (100%) CNAs educated by 9/22/25. New employees will be educated on Abuse, Neglect and Exploitation policy during Facility Orientation process. *From 9/16/25 through 9/21/25 - Nursing Leadership provided education to all staff regarding the Elopement Policy. Elopement education included: elopement policy and procedure, correct positioning for screamers, interventions with wandering behaviors, response to door alarms, Code Silver for Missing Resident, and control of key belonging to screamer. 11/11 (100%) Therapy Department received elopement education by 9/18/25.11/11 (100%) Dining Department received elopement education by 9/18/25.52/52 (100%) CNAs received elopement education by 9/21/25.32/32 (100%) Nurses received elopement education by 9/21/25.106/106 (100%) of Team Members Educated on elopement education by 9/21/25. New employees continue to be educated on Elopement Policy and Procedure, correct positioning of screamers, interventions with wandering behaviors, response to door alarms, Code Silver for Missing Resident, and control of key belonging to scream during Facility Orientation process. *Elopement drills initiated for every shift on 9/16/25 with 43 team members having participated by 9/18/25. Elopement drills were then completed daily from 9/20/25 through 9/29/25, then monthly from 9/30/25 through 10/16/25. Most recent elopement drill completed 10/16/25. *On 9/20/25 - facility initiated Weekly Review of Door Audits and Care plans for residents deemed to be at risk of elopement at Morning Stand-Up Meeting with IDT.Meeting held 10/01/25. Meeting held 10/08/25. Meeting held 10/15/25. *On 9/24/25 - regular QAPI meeting held with (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administrator, DON, Medical Director and members of the IDT to review and interpret all audits and findings. No issues or discrepancies found within audits. The Medical Director did not have any further recommendations. *On 10/16/25, the IDT met, in lieu of Ad-Hoc QAPI meeting, and reviewed findings of 30-Day Door check Audits. Audits were noted to be at 100% compliance. Audits of team member education on Elopement Policies and Procedures and Abuse, Neglect and Exploitation protocol found to be at 100%. The Medical Director was advised of results via phone on that date. After discussion and review of door and education audits, IDT team found the facility to be in Substantial Compliance as of this date. Interviews were conducted on 11/18/25 and 11/19/25 with 22 staff members representing all shifts (2 Registered Nurses, 4 LPNs, 10 CNAs, 2 maintenance staff, 1 housekeeper, 1 dietary staff, 1 therapist and 1 activity staff). Staff interviews revealed they were knowledgeable of the elopement policy and procedures, appropriate response to alarms and supervision of all residents to include those at risk for elopement, abuse and neglect. The resident sample was expanded during the survey to include three additional residents who were at risk of elopement. Observations, interviews, and record reviews conducted revealed no concerns related to elopement risk evaluations, care plans and physician orders for residents #4 through #6. Based on the facility's corrective actions, the survey team determined the facility was in substantial compliance on 10/16/25.		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision to maintain a secure environment to ensure vulnerable residents did not exit the facility without supervision for 1 of 6 residents reviewed for elopement, of a total sample of 6 residents, (#1). These failures contributed to the elopement of resident #1 and placed him at risk of serious injury, impairment or death. While resident #1 was outside the unit unsupervised, there was reasonable likelihood he could have gone to the roof and fallen off, fallen down the stairs with his walker or been hit by a car. On 9/16/25 at approximately 2:00 PM, the facility failed to prevent a resident with severe cognitive impairment from exiting the facility unsupervised. The facility was unaware of resident #1's whereabouts until he was observed outside on the sidewalk by a maintenance staff member at approximately 2:15 PM and returned to the unit at approximately 2:30 PM. The facility failed to ensure resident #1 was adequately supervised to ensure vulnerable residents did not exit the facility into unsafe areas without staff knowledge. Review of information provided by the facility revealed a total of 5 residents were identified as at risk for elopement on the first day of survey. The facility's failure to provide adequate supervision resulted in Immediate Jeopardy starting on 9/16/25 which was removed on 9/19/25. The scope and severity of the deficiency was decreased to a D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. The noncompliance at F689 was determined to be past noncompliance as of 10/16/25. Findings: Cross reference F600. Resident #1, an [AGE] year-old male, was admitted to the facility on [DATE]. His diagnoses included unspecified dementia, metabolic encephalopathy, unsteadiness on feet, muscle weakness and other abnormalities of gait and mobility. Review of resident #1's electronic medical record (EMR) revealed he had resided in an Assisted Living Facility (ALF) Memory Care unit prior to his hospitalization and subsequent admission to the nursing home for rehabilitation services. Review of the Minimum Data Set (MDS) admission assessment with assessment reference date of 9/10/25 revealed resident #1 had a Brief Interview for Mental Status score of 3/15 which indicated he had severe cognitive impairment. The assessment indicated resident #1 used a wander/elopement alarm daily but did not exhibit wandering behavior during the review period. It was noted that resident #1 ambulated with the use of a walker but an evaluation of his ability to go up and down steps was not attempted due to his medical conditions and/or safety concerns. The EMR contained an elopement risk assessment dated [DATE] which indicated resident #1 was at risk for elopement. The record also contained a fall risk assessment dated [DATE] which indicated he was at high risk. Review of resident #1's physician orders revealed an order dated 9/03/25 for an electronic wander alert bracelet to be applied to resident #1's wrist. A progress note dated the same day indicated the wander alert bracelet was placed on resident's left wrist. Review of resident #1's care plan revealed a care plan initiated 9/25/25 which indicated resident #1 was at risk for fall and fall related injury related to weakness, decreased safety awareness, impaired balance and cognitive impairment. The comprehensive care plan did not contain a care plan for elopement or wander risk prior to his elopement on 9/16/25. On 11/17/25 at 4:15 PM, Licensed Practical Nurse (LPN) C verified she was at work on the day resident #1 got outside the facility but was not assigned to him. She explained she was aware of who he was and had seen him earlier in the morning that day and again around lunchtime between 12:30 - 1:00 PM. LPN C could not recall if she saw resident #1 again that day. She reviewed the statement she provided to the facility and acknowledged she had informed the facility she saw resident #1 around 2:00 PM that day. LPN C verified the resident was cognitively impaired and used a walker for ambulation. Review of Certified Nursing Assistant (CNA) B's witness statement given on 9/16/25 revealed she last saw resident #1 in his room at 2:00 PM. She reported he was fully dressed, lying on his bed and was watching television. CNA B's statement indicated she went to the room next door to (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	take another resident's vital signs and proceeded to assist another CNA with room rounds. CNA B was unavailable to be interviewed by facility or surveyor. On 11/17/25 at 1:28 PM, Maintenance Technician A verified he was part of the maintenance team. He explained he worked all over the facility campus. He recalled on the day resident #1 eloped, he was returning from the garbage compactor area to the front of the facility in a golf cart. He stated he noticed a resident outside with his walker who appeared to be looking around for something. Maintenance Technician A explained he stopped the cart and walked over to check on him. The technician reported he realized the resident may need help and called the Assistant Maintenance Director for assistance. Maintenance Technician A stated he remained with resident #1 until other staff arrived, then left and went back to work. On 11/17/25 at 1:54 PM, the Assistant Maintenance Director stated he was working around the facility trying to complete work orders when he received a call from Maintenance Technician A. He recalled going to help when he realized resident #1 was from the nursing unit and notified other staff that he was found outside. The Assistant Maintenance Director recalled he asked resident #1 what he was doing outside. He reported resident #1 responded that he was trying to go across the road into the woods where he left his car. The Assistant Maintenance Director recalled resident #1 had a walker and was wearing a short sleeve shirt, pants and socks but no shoes. On 11/17/25 at 2:04 PM, the Activities Manager confirmed she was working the day resident #1 got outside the facility. She explained she was very familiar with him. She recalled she was coming out of her office in the ALF Memory Care unit and saw resident #1 outside on the sidewalk. She explained she ran outside and found the maintenance staff with him by the time she reached him. She recalled he had his walker with him. The Activities Manager stated resident #1 told her he wanted to get to the other side of the parking lot to his car. She explained she accompanied him back inside where they were met by the former Director of Nursing (DON) and they proceeded up the elevator back to the nursing unit. She was unable to explain how resident #1 could safely manage to descend a staircase from the second floor with his walker. In a phone interview on 11/18/25 at 10:12 AM, the former DON recalled the day resident #1 got outside the facility. She stated she could not remember the exact date and times since it was almost two months prior. She explained she was notified of resident #1 being outside and went to the back door to meet the staff who had gone outside to bring him back to the nursing unit. She recalled the resident was wearing socks but no shoes. She reported he soiled his pants and was changed but had sustained no injuries or skin impairments. She stated he was immediately placed on one-on-one (1:1) observation and an investigation was initiated. The former DON recalled resident #1 told her he went down the stairs. She explained staff attempted to re-enact the event and determined resident #1 must have exited through the emergency exit door. She stated the door malfunctioned and the door alarm did not sound or lock the way it should have. She recalled there were contractors working in the unit on the call bell system that day. The former DON insisted the contractors did not use the emergency exit door, but the work may have affected the door function. The former DON stated she did not know how he got down the stairs safely with his walker. On 11/17/25 at 1:36 PM, the Maintenance Director was accompanied to the stairwell emergency exit door in the nursing unit. The door was noted to have a wander alert sensor, a red screamer alarm and a sticker on the door which indicated it was a 15-second egress door. He explained the wander sensor and 15-second egress were controlled by electric current, but the red screamer alarm was battery operated. The Maintenance Director stated the 15-second egress alarm malfunctioned and the red screamer did not sound which allowed resident #1 to exit through the second-floor stairwell emergency exit door without alerting staff. On the other side of the door was a staircase leading up to the roof and another staircase leading down to the bottom floor. In a follow-up interview on 11/18/25 at 1:40 PM, the Maintenance Director stated door audits were conducted every day immediately following the event which then moved to a weekly check. He clarified there were no documented regular door checks prior to the event. The Maintenance Director explained the maintenance department only checked the doors prior to the elopement if there was a report of them not working properly. On 11/18/25 at 11:58 AM, (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the MDS Coordinator reviewed resident #1's comprehensive care plan. She acknowledged neither a baseline care plan nor a comprehensive care plan had been developed prior to the event to identify the elopement risk or to provide interventions for the at-risk behavior. The MDS Coordinator was unable to explain why a care plan had not been initiated prior to the event. In a phone interview on 11/18/25 at 10:34 AM, resident #1's responsible party confirmed he was notified of the event. Resident #1's responsible party verified the resident was cognitively impaired and had previously resided on the memory care unit at the ALF in the building. He stated resident #1 had previously been identified by the facility as an elopement risk. In a joint interview with the Administrator and DON on 11/17/25 at 3:24 PM, the Administrator stated the facility initiated an investigation and corrective measures immediately following the elopement on 9/16/25. He explained the facility held an Ad-HOC Quality Assurance and Performance Improvement (QAPI) meeting on 9/19/25 to review the outcome of the facility's investigation. The Administrator reported their investigation showed that resident #1 exited the facility between 2:00 - 2:15 PM through the second-floor stairwell emergency exit door on the nursing unit. He explained they had reviewed videos from the lobby and unit doors, and resident #1 was not seen on the camera footage. He expressed the only other exit route off the unit was through the emergency exit stairwell door. The Administrator stated they were able to determine the time from statements given by CNA B, his assigned CNA, and LPN C. He explained the wander sensor on the stairwell door was not engaged to work because it was a delayed egress door which should have been locked. He reported the facility determined the alarm for the 15-second egress door temporarily malfunctioned and did not lock or alarm when resident #1 exited through the door. The Administrator added that the investigation revealed the red screamer alarm was found to have been turned to the off position by a staff member. He explained the red screamer alarm could only be turned off with a key which only maintenance and licensed nursing staff had. He verified the facility was unable to determine which staff had turned the alarm off. The Administrator acknowledged this created an unsecured and unsafe environment which enabled resident #1 to exit through the stairwell emergency exit door, descend down a flight of stairs and ultimately exit the facility. Review of the policy and procedure for Elopement and Wandering Residents reviewed 9/17/25 revealed an elopement occurred when a resident left the premises or a safe area without authorization and/or necessary supervision to do so. The document indicated that a resident who was at risk for elopement would receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The document provided information that while the facility was equipped with door locks/alarms to help avoid elopements, they were not a replacement for necessary supervision. On 11/17/25, resident #1's likely elopement route was retraced. He exited the nursing unit located on the 2nd floor through the unit's emergency exit door and entered a stairwell with stairs leading up to the roof or down to the first floor. Resident #1 descended 11 stairs with his walker to a concrete landing and then continued down another 10 steps with his walker to the bottom of the staircase. He turned to his right and exited the facility through a door leading to the outside. He proceeded to walk approximately 154 feet on a sidewalk alongside a parking area and a two-lane drive where he was stopped by a maintenance staff member. There was a likelihood resident #1 could have gone to the roof and fallen off, fallen down the stairs with his walker, walked into the driveway and been hit by a car causing serious injury, harm or death. Historical weather data revealed on the day resident #1 eloped, 9/16/25, the temperature at 1:53 PM was 88 degrees Fahrenheit and fair skies, (retrieved on 11/18/25 from www.wunderground.com). Review of immediate corrective measures implemented by the facility revealed the following, which were verified by the survey team at the time of the survey: *Resident was returned to the facility on 9/16/25 at 2:30 PM by facility staff and was assessed by former DON upon re-entry into facility with no signs of injury or dehydration noted. *Resident #1 was immediately placed on 1:1 monitoring upon his return on 9/16/25 at 2:30 PM and remained on 1:1 monitoring until his discharge on [DATE]. *On 9/16/25 at approximately 2:45 PM - a census headcount was (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Legacy Pointe at Ucf		STREET ADDRESS, CITY, STATE, ZIP CODE 2120 Hestia Loop Oviedo, FL 32765	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	completed. *On 9/16/25 at 3:09 PM - the physician was notified of resident #1 being observed outside. * On 9/16/25 at approximately 4:00 PM - the Assistant Director of Maintenance checked the alarm and keypad for function on the unit entrance door and the stairwell emergency exit door. *On 9/16/25 - a 24-hour door monitor was initiated at the stairwell emergency exit door. The door was monitored by facility staff. Unit entrance door and kitchen door were assessed by maintenance and determined to be in working order. *An Elopement Risk Assessment was completed for resident #1 on 9/16/2025 at 4:28 PM by the Nursing Supervisor. *A head-to-toe assessment was completed by nurse on duty on 9/16/25 at 4:45 PM with no injuries or adverse effect noted. Vital signs were within normal limits. *Elopement Risk Assessments for all residents were updated on 9/16/25 by the Nursing Supervisor. *An Elopement Risk Care plan for resident #1 was initiated on 9/16/25 by the MDS Coordinator. *Resident #1's responsible party was contacted on 9/16/25 at 5:26 PM by the former Director of Nursing. *On 9/16/25 - the DON or designee began auditing new admissions for elopement risk and ensuring appropriate interventions were in place. *On 9/16/25 - door check audits were initiated to check functionality and screamer positioning for unit entrance door, back stairwell exit-door and kitchen door. Door check audits continued every shift through 10/16/25. *On 9/16/25 - the Administrator and DON began monitoring for exit seeking behavior and elopement risk during daily community rounds and will continue monitoring. *On 9/17/25 - the Interdisciplinary Team (IDT) began to monitor the 24-hour report during morning stand-up meeting for potential elopement risks/exit seeking behavior and will continue to monitor in morning stand-up meetings. *On 9/17/25 - initiated DON/designee to monitor new admissions for accuracy of elopement risk screens and ensure appropriate interventions are in place. *On 9/18/25 - the stairwell emergency exit delayed egress alarm system was inspected by the vendor, serviced and confirmed operational. *On 9/18/25 - the 15-second delayed lock on the stairwell emergency exit door was adjusted to immediate locking when the door moved from open to closed position. *On 9/18/25 - the delayed egress screamer was reconfigured to alert when pressure was applied to the back door, rather than when the door physically opens. *On 09/18/25 - digital notifications were added to nursing iPads to alert staff of activity near delayed egress doors and to notify if pressure was applied to those doors. *On 9/19/25 - An Ad-Hoc QAPI meeting was held with the Administrator, DON, Medical Director and members of the IDT to discuss the event. A PIP was implemented to review and interpret all audit findings. *From 9/16/25 through 9/21/25 - Nursing Leadership provided education to all staff regarding the Elopement Policy. Elopement education included: elopement policy and procedure, correct positioning for screamers, interventions with wandering behaviors, response to door alarms, Code Silver for Missing Resident, and control of key belonging to screamer.11/11 (100%) therapy department staff received elopement education by 9/18/25.11/11 (100%) dining department staff received elopement education by 9/18/25.52/52 (100%) CNAs received elopement education by 9/21/25.32/32 (100%) nurses received elopement education by 9/21/25.106/106 (100%) of team members educated on elopement education by 9/21/25.New employees continue to be educated on Elopement Policy and Procedure, correct positioning of screamers, interventions with wandering behaviors, response to door alarms, Code Silver for Missing Resident, and control of key belonging to scream during Facility Orientation process. *Elopement Drills initiated for every shift on 9/16/25 with 43 team members having participated by 9/18/25. Elopement drills were then completed daily from 9/20/25 through 9/29/25, then monthly from 9/30/25 through 10/16/25. Most recent elopement drill completed 10/16/25. *On 9/20/25 - facility initiated weekly review of door audits and care plans for residents deemed to be at risk of elopement at Morning Stand-Up Meeting with IDT.Meeting Held 10/01/25. Meeting Held 10/08/25. Meeting Held 10/15/25. *On 9/24/25 - regular QAPI meeting held with Administrator, DON, Medical Director and members of the IDT to review and interpret all audits and findings. No issues or discrepancies found within audits. The Medical Director did not have any further recommendations. *On 10/16/25, the IDT met, in lieu of Ad-Hoc QAPI meeting, and reviewed findings of 30-Day Door check Audits. Audits were noted to be at 100% compliance. Audits of team (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	member education on Elopement Policies and Procedures and Abuse, Neglect and Exploitation protocol found to be at 100%. The Medical Director was advised of results via phone on that date. After discussion and review of door and education audits, IDT team found the facility to be in substantial compliance as of this date. Interviews were conducted on 11/18/25 and 11/19/25 with 22 staff members representing all shifts (2 Registered Nurses, 4 LPNs, 10 CNAs, 2 maintenance staff, 1 housekeeper, 1 dietary staff, 1 therapist and 1 activity staff). Staff interviews revealed they were knowledgeable of the elopement policy and procedures, appropriate response to alarms and supervision of all residents to include those at risk for elopement, abuse and neglect. The resident sample was expanded during the survey to include three additional residents who were at risk of elopement. Observations, interviews, and record reviews conducted revealed no concerns related to elopement risk evaluations, care plans and physician orders for residents #4 through #6. Based on the facility's corrective actions, the survey team determined the facility was in substantial compliance on 10/16/25.		