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
	AL11964388	A. BUILDING: _____ B. WING _____	R 07/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMETTO LANDING	1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 000}	Initial Comments A revisit to Complaint Investigations 2019011243 and 13084 was conducted at Palmetto Landing on , , . Deficiencies were found to be uncorrected at the time of the visit.	{A 000}		
{A 025} SS=D	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must 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 an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 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 58A-5.020, 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.	{A 025}		

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{A 025}	Continued From page 1 (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 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 properly supervise 1 of 3 sampled residents (#14.) Findings: Resident #14's current 1823 health assessment form, dated , indicated that her diagnoses included , , and 's . At 10:06 a.m. on resident #14 was asked by the surveyor whether she recalled ever being on the floor in another room. She said she did not know how she would have ended up in a different room and she could not recall any details of that ever occurring. At 12:48 p.m. on , nurse I said on the morning of she arrived at work, read the 24-hour shift report and learned resident #14 had a . At approximately 7 a.m. the nurse was conducting her rounds and when she entered	{A 025}		

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{A 025}	Continued From page 2	{A 025}		

resident #14's room, the resident was not in there. The nurse said resident #14 could get up but would not have been able to get herself out of her room while in her wheelchair. The nurse asked around, but no one knew where the resident was. The nurse assumed the resident was sent to the hospital. The nurse continued to check other resident's and give . When the administrator arrived at the facility at approximately 9 a.m., the nurse asked the administrator about it and the administrator said that resident #14 was not sent to the hospital. The nurse told the administrator the resident could not be located. Between 9 a.m. and 10 a.m. the nurse, along with other staff, searched and found the resident behind the closed door and on the floor of . The resident's wheelchair was in the room, she was not hurt and could not explain what happened.

At 1:19 p.m. on , staff A said she arrived to work at 6 a.m. on . At approximately 7 a.m. she saw that resident #14 was not in her room. Staff A was told, she could not remember by whom, that the resident was in the hospital. Staff A said sometime that same morning, she could not remember the time, the resident was located on the floor of .

The resident's record did not contain documentation regarding the incident.

At 2:05 p.m. the administrator said that at approximately 9:30 a.m. on nurse I came to her office and asked whether resident #14 was in the hospital and the administrator replied no. Nurse I went to look for the resident then returned to the administrator and reported that the resident had been located in another room. The administrator said the resident can, in fact,

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{A 025}	Continued From page 3 propel herself in her wheelchair and believed the resident got turned around and wheeled herself into the wrong room. The administrator confirmed the resident's record did not contain documentation of the incident. Review of the 24-hour shift reports from . . . and revealed there was no documentation to indicate resident #14 was sent to the hospital. At 4:07 p.m. on . . . . , caregiver J said she last provided care to resident #14 on at approximately 5 a.m. and the resident was in her own room. Class III	{A 025}		
{A 152} SS=D	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to Section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable . . . to ensure easy access by the resident;	{A 152}		

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{A 152}	Continued From page 4 2. A closet or wardrobe space for hanging clothes; 3. A dresser, ... or other furniture designed for storage of clothing or personal effects; 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on observations and interviews, the facility failed to ensure the carpet was free of damage. Findings: At 8:39 a.m. on . . . . . , a bleach stain remained on the carpet near in the memory care unit. Nurse J and caregiver K were both present and both confirmed the finding. (photographic evidence obtained.) Class III	{A 152}		