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
	AL11969022	A. BUILDING: _____ B. WING _____	R 09/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING FACILITY	2250 S SEMORAN BLVD ORLANDO, FL 32822

(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 Investigation #2020012336 was conducted on [redacted]. Assisted Living Facility had a deficiency uncorrected at the time of the visit.	{A 000}		
{A 025} SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. 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. 59A-36.007 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.	{A 025}		

AHCA Form 3020-0001

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

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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: DEFICIENCY REMAINED UNCORRECTED Based on resident record review, Medication Observation Record review and interview, the facility failed to ensure prescribed medications, including , medications, were available and reordered in a timely manner, which resulted in 1 of 6 sampled residents experiencing , (#8), and the facility failed to have written documentation that the healthcare provider and family were notified after a significant change (Hospice admission) for 1 of 6 sampled residents (#1). Findings: 1. On at 10:30AM, resident #8 stated she had lived in the facility about 1 year. She said the staff brought her medications to her room, but she is often told they have run out of some of her prescribed medicines. She was especially concerned about missing her , medication. She stated, "It seems like they do not reorder	{A 025}		

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{A 025}	Continued From page 2 them in time, especially my , medicines. They say they have to wait for the doctor to come here before he can sign the prescription." The resident stated she is in great , when she does not get her medication. Resident #8's record revealed an admission date of . Her current 1823 was date and noted diagnoses including , and , . She required assistance with bathing, , toileting and transferring, supervision with ambulation and grooming, and was independent with eating. She required assistance with self-administration of medications. Review of the and , Medication Observation Records (MORs) revealed the following medications were marked as not available on the following dates: , , 10 milligrams (mg.) 1 tablet at bedtime, written on . "Hold if , ". Marked as "med not available" on all 31 days in , and on , , and . A new order without parameters was received on but the medication was still not available on and . The resident did not have this medication available in and , for 36 days. 0.1 mg. 1 tablet at bedtime, hold when less than , written on with no end date. There was also an order written to end on with the instructions to give every 6 hours as needed for , greater than 150 or diastolic , greater than 90. The medication was marked as "refused" or "held" when the , was outside of	{A 025}		

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{A 025}	Continued From page 3 parameters 34 times from /2020. Then it was marked as "med not available" at 12:30 AM, and then given on at 6 AM. The MOR was marked with an "X" for the bedtime dose on - with no explanation. On , the note indicated "med not available- calling pharmacy" and then was noted to be "not available" from on all days from through . The resident did not have this medication available for 24 days in until . , 100 micrograms/hour (mcg/hr) patch, apply patch , every 3 days was marked as removed on , but a new patch was not placed. On , , and , it was noted "med not available-backorder." The patch was marked as placed on , blank on , and placed on . On , the patch was again noted to be on backorder. The resident did not have this medication available for 6 placement days, or 18 days. , extended release (ER) 15 mg. one tablet daily, written on with no end date. The MOR was marked with an "X" on /2020 with no explanation, and then marked as "med not available" or "backorder" or "order placed" on through . It was marked as given on . The MOR was blank on , and on /20202 was again marked as "not available." On , , , and , the MOR was marked as "med not available", but was marked as given on . The resident did not have this medication available for 36 days in through . (photographic evidence obtained)	{A 025}		

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{A 025}	Continued From page 4 On [redacted] at 2:20 PM, the director of nursing (DON) stated she recently became aware of the issue and they were working on it. She stated she learned the staff would mark on the MOR if a medication was not in the cart, but never told the DON or followed up with the pharmacy. She said she was working to make sure medications were ordered in advance. 2. Resident #1's record review revealed a date of admission [redacted] and then admitted to Hospice care with an interdisciplinary care plan on [redacted]. The facility did not have written documentation in the progress notes that the healthcare provider and family were contacted of the significant change and decline in health. At 2:10 PM on [redacted], the Director of Nursing said there no written documentation in the progress notes that resident #1 went to hospital on [redacted] and returned to the assisted living facility on Hospice care. {Photographic Evidence Obtained} Class II	{A 025}		