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
	AL11965667	A. BUILDING: _____ B. WING _____	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR OAKS AT GREENACRES	3400 JOG RD GREENACRES, FL 33467

(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 An unannounced Licensure Complaint, #2020008969, Focused Control and Generator Assessment survey, was conducted on through at Arbor Oaks at Greenacres. The facility had a deficiency identified at the time of the survey.	A 000		
A 025 SS=D	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 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 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 025		

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A 025	Continued From page 1 (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 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 interview and record review, the facility failed to provide care and services appropriate to the care needs of Residents admitted to the facility for 2 out of 10 sampled resident records reviewed (Resident #1 and #8). The facility also failed to contact the Resident's physician and Representative when the resident demonstrated signficiant behavioral changes; and to maintain written record of notification and the health changes, for 2 out of 10 sampled resident records reviewed (Resident #1 and #8). As evidenced of the facility failure to implement its change in condition and resident assessment policies and procedures by not ensuring residents (Residents	A 025		

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A	Continued From page 2 #1 and 8) received updated resident assessments and periodic resident supervision. The Findings Include: Review of the facility's undated "change in condition" policies and procedures, indicated that the facility must act to provide appropriate care to each resident whenever a resident underwent a change in condition. Review of this document indicated that the facility nurse must complete a "potential change in condition/status notification form" for each resident whenever a resident change in condition happened which included but was not limited to elopement. Further review of this document indicated that facility nurse must document the facility's interventions applied for the resident's change in condition and the resident's response of the action taken by the facility. Review of the facility's undated elopement prevention policies and procedures indicated that the facility must identify residents who are at risk for elopement such as residents who . . . and have . Review of this document indicated that every resident will be assessed for elopement risk before admission using the "pre-admission elopement risk assessment, risk assessment elopement decision tree and family intervention discussion forms." Further review of this document indicated that every resident with an elopement risk will receive supervision and periodic checks, and a revised assessment after any elopement or exit-seeking behavior has occurred to implement additional prevention interventions. Review of the facility's undated, "quantitative assessment of resident need" policies and	A 025		

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A 025	Continued From page 3 procedures indicated that the facility must provide care to each resident based on their assessed needs. Review of this document indicated that the facility was to complete a "monthly assessment form" for each resident to determine the amount of care needed and if a resident's service plan needed adjustment. Review of the facility's undated, "pre-admission appraisal (assessment)" policies and procedures indicated that the facility nurse must gather pre-admission data on every resident to determine the need and type of services the residents required. Review of this document indicated that the facility nurse must communicate any identified resident significant risks to the Administrator . In an interview with the Administrator on 11- . . . . at 11:30am, she stated that Resident #1 was admitted to the facility on . . . . . as an Assisted Living resident. However, the resident would be placed in the Memory Care (Evergreen) from time to time as he needed additional supervision and it could be provided there as it was a smaller unit. During review of Resident #1 facility file on . . . . . this Surveyor conducted a review of Resident #1 Agreement which stated on Page 3, section 5: Services/Level of Care - Upon Admission or prior to admission, each resident will be assessed to determine the appropriate level of care to meet the resident needs. During the first 30 days of your stay with us, we will complete a reassessment to verify that we are providing you with the appropriate level of care. Thereafter, we will quarterly, and every three (3) years thereafter or right after a significant change, reassess your needs to determine whether your	A 025		

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A 025	Continued From page 4 condition has changed. If our reassessment indicates that the level of care we are providing you is not appropriate for your needs, we will consult with you and then change your Level of Care and related fees. We will also notify your Responsible Person(s) of the change." During interview with (family member) on . . . . . at 11:02 AM, she stated that she had not given permission for the resident to be placed in Memory Care and that he hated being in there. She further stated that her son did not agree for him to be paced there and would never have done so. She stated she wrote an email and I told [Administrator], that she didn't want him in there. "That one time when they told me they put him there because he was trying to escape, but he wasn't. I told them he didn't like that. He looked so out of place. (Resident #1) didn't like that." She further stated that she was concerned about his health, specifically his protein intake as she was advised by facility staff that he was getting soft foods. A review of resident #1's AHCA form 1823 dated revealed that he was on a regular diet. During an interview with the Resident Care Coordinator on at 2:40 PM, he stated Resident #1 used walker, was alert and oriented x2, had history of , memory loss associated with Memory loss. On days when he would say he was leaving the facility we would contact the family to get them to have him placed in Memory Care. He further stated that Resident #1 was encouraged to go to the locked unit because of exit seeking behavior. Specifically, he would go up to the exit doors and try to get out, sometimes stating he was going home to his wife, I'm out of here, you can't stop me. Sometimes we would put Resident #1 on the phone with his wife	A 025		

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A 025	Continued From page 5 or family to try and get him to Evergreen. Other times we would try to encourage him, and he would go. He stated Resident #1 would be placed in the Memory Care with the family's notification and agreement, and the physician being notified, we would put him in Evergreen. During interview with caregiver B on at 3:09 PM, who works in Memory Care (Evergreen), she stated that Resident #1 was very nice, sweet, respectful man, but saw him belligerent on occasion. When he became belligerent or uncontrollable, he would be placed in Memory Care. During interview with Nurse C on at 3:23 PM who works in Memory Care (Evergreen), she stated Resident #1 was a part of the Assisted side and observed him in Memory Care. She stated that after dinner time he would get . . . . . and want to leave and they would put him in the Memory Care. Review of Resident #1's Resident Observation Log and entries revealed the following: a) at 7:30 PM: Resident states "he'll jump from the 2nd floor" (Nurse B) called, wants him in Evergreen for safety. Wife (name) also notify." b) ( ): Resident was in Evergreen today and from resident reaction, it shows that he had a good day in Evergreen. c) ( ): Resident refused diner, took half of diet coke & a few swallows of Boost. Refused all meds 3 attempts. "Stated I told you no!" Continues in Evergreen.	A 025		

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A 025	Continued From page 6 Review of Resident #1's facility files and records also revealed undated facility notes revealing the following: a) ... .: (Resident #1) was found by dumpster. He refused to come in. He was very aggressive. The nurse told him (family member) was inside he followed very unhappily .. into building. (Resident #1) was taken into Memory Care. His wife was made aware. (Resident #1) finally relaxed and had a good rest of the day. b) ....: (Resident #1) is refusing care. He was very aggressive (-written: put in memory care). c) .. .. (Resident #1) was sent to memory care. He was found going down the steps in the 300 hallway. He was very agitated. No one could redirect. He was trying to find an exit. Review of Resident #1's Health Assessment (AHCA form 1823) signed on .... revealed the resident was diagnosed with , ... , ..., ... It also indicated Resident #1 was an Elopement Risk. During interview with the Administrator on . ... at 2:51 PM, she restated Resident #1 came to the facility as an Assisted Living resident. She stated Resident #1 talked about leaving, would come out of his room not dressed, he was belligerent, needed to monitored eating and that he needed more supervision and guidance, and that in the Memory Care Unit (Evergreen) they could do that because it's a smaller unit. She further stated that Resident #1 would be put Evergreen (Memory Care) because he required additional supervision and that his level of care	A 025		

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A 025	Continued From page 7	A 025		

had changed. However, no documentation was observed in the resident file or resident record indicating that an updated Health Assessment (AHCA form 1823) had been completed as required to update the resident's change of condition. The file also filed to reflect any assessments due to Resident #1's signficiant behavioral changes.

During an interview with the Administrator on [redacted], she stated that Resident #1 needed to be in Evergreen (MC) and that a state entity agreed and advised that he needed to be in Memory Care. She stated that the facility had spoken with the doctor but had not completed the paperwork. She further stated that she spoke with the wife and she stated that they did not want to do that at this time. And that she spoke with the son as well regarding Resident #1 going to the Memory Care unit. She stated he said "yes" at first, then "no". This Surveyor gave her an opportunity to locate documentation of her conversation with the son in the resident's file. She was unable to.

This Surveyor requested the facility's Reassessment/Change Form referenced in their policy/procedures that was completed for resident #1 as observation by this Surveyor revealed that this form is also used when recommending/transferring a resident from Assisted Living to Memory Care. She stated she was going to do one but did not have one.

During interview with the Administrator on [redacted] at 2:51 PM, this Surveyor inquired as to whether Resident #1 had been reassessed. She stated on the Monthly assessments, and that they were working with the doctor on completing the AHCA form 1823. Review of the resident's file

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A 025	Continued From page 8 did not reveal documentation of conversation with the resident's physician regarding the change in his status. The Administrator was provided an opportunity to review the file and was unable to locate documentation related to completion of an updated AHCA form 1823 reflecting resident's change of condition. 2) In an interview with the Administrator on /20202 at 11:30am, she stated that Resident #8 was admitted to the facility on around 12:00pm and that the resident was transferred to the facility's memory care unit (MCU) the same day since the resident exhibited exit-seeking behavior. She stated that shortly after the resident was dropped off by the resident's family member on , the resident was taken to her room in the standard area of the facility and shortly thereafter, the resident began saying that she wanted to leave the facility as she walked around the lobby area. She stated that it was obvious that the resident had exit-seeking behaviors on , which was considered as an attempt to elope from the facility. Review of Resident #8's health assessment dated on indicated that the resident was diagnosed with , high risk, and . Review of this health assessment indicated that the resident had some and forgetfulness and required assistance with ambulation and supervision with all of her other activities of daily living. Further review of this health assessment indicated that the resident was not an elopement risk. Review of the facility nursing admission assessment dated on indicated that the resident was originally in the standard side of	A 025		

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A 025	Continued From page 9 the facility, in . . . . , and since the resident was and tried to leave the facility, the resident was placed in the MCU. Review of this assessment indicated that the resident was alert and unaware, and able to be re-directed. In an interview with the Administrator on at 1:10pm, she stated that Resident #8 was admitted to the facility on . . . . . without the facility nurse conducting an assessment on the resident first. She stated on after the resident was admitted and the resident verbalized that she wanted to go home, she signaled for the nurse on shift to move the resident to the MCU due to this exit-seeking behavior. She stated that after the resident was in the MCU, the resident received the facility's admission assessment from the nurse. She stated that she told the nurses to have the resident stay in the MCU and that the resident's exit-seeking behaviors have not been assessed after . She stated that the facility did not create an incident report for the resident attempting to elope on and that the facility did not have any specific policies and procedures relating to the placement of residents in the MCU which was an access-controlled area in the facility. On at 3:41 PM, the Survey team conducted an Exit Interview with the Administrator via telephone. The findings were discussed with the Administrator , she stated she understood. Class III	A 025		