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
	AL11968157	A. BUILDING: _____ B. WING _____	11/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENADES BY	425 S RONALD REAGAN BLVD LONGWOOD, FL 32750

(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 complaint investigation #2020002215 was conducted at Serenades By on and . Deficiencies were identified at the time of survey.	A 000		
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 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) Monitoring of the quantity and quality of resident diets in accordance with rule	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 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 record review, hospital record review, medical examiner report and interview, the facility failed to provide adequate supervision to meet the needs for 1 of 5 sampled residents (#4), and the resident sustained a , and injury that required acute care. Findings: Resident #4's record reflected that the resident resided in a secured memory care unit. A resident health assessment form 1823, dated , included diagnoses of 's , of right , and history of . The resident required assistance with all activities of daily living (ADLs), included	A 025		

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A 025	Continued From page 2 bathing, [redacted], grooming, toileting, ambulation, transfers and eating. Resident #4 was admitted to hospice services on [redacted]. A nursing updated hospice Comprehensive Assessment, dated [redacted], noted the resident as total care with all ADLs. Interventions on the assessment included 2-person transfer, to have a caregiver with the resident, bed low position and a floor mat, to decrease [redacted]. Resident #4's facility notes revealed that on [redacted] at 8:24 PM, the resident was found on the floor on a blue mat at the bedside. The resident sustained a [redacted] to the forehead and left [redacted]. The [redacted] were cleaned, and [redacted] was applied. On [redacted] at 5:26 AM, an electronic facility note reflected that the hospice nurse sent resident #4 to the hospital for [redacted] to the forehead. On [redacted] at 10:41 AM, an electronic facility note reflected that the hospice nurse went to assess resident #4 at hospital and found that she had a right [redacted] and [redacted] to the forehead. The hospice nurse felt she would be admitted to the hospice inpatient unit for [redacted] management. On [redacted] at 11 AM, the wellness director said resident #4 [redacted]. She said staff A was providing care to the resident in her bed that had an air mattress, turned her on her side and walked away to obtain something from the closet that was across from the bed. When he turned around, he observed the resident falling out of bed. She said the resident was transported to the emergency room and was later placed in the hospice inpatient unit, where she later [redacted]	A 025		

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A 025	Continued From page 3 On at 11:15 AM, the administrator and the wellness director were asked to provide documentation of the facility's investigation regarding the . The wellness director said she did complete an investigation but did not have documentation. She said the Department of Children and Families (DCF) Adult Protective Services (APS)representative completed their investigation and recommended additional training for the staff. They both said they considered the an accident and only took the recommendations of the DCF APS representative to provide training for the facility staff. A review of the staff training revealed it was completed on for all staff, including staff A. The 1-hour training, titled " Prevention for the Elderly Population", was conducted by a hospice representative, eighty-six days after the resident . There was no in-service training provided by the facility to the staff, such as safety while providing ADL care in order to prevent incidents, such as that which occurred with resident #4. Interview with the Administration and the wellness on at 11:15 AM revealed they felt the was an accident and did not feel they had control over the . On at 3 PM, staff A said he was often resident #4's caregiver and was familiar with her. He said on the day of the incident, he wheeled resident #4 into her room to provide care for her, placed her in her bed, raised the bed because it was in the low position, and removed her pants. He said he checked to determine if he needed to change her adult brief. He said he realized there was no garbage bag to dispose of the adult brief. The garbage bag was in the closet. He said he lowered the bed and placed the resident on her side because she would move around sometimes	A 025		

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A 025	Continued From page 4 in the bed. He said he thought she would be safer to be turned on her side while he stepped away to get the garbage bag. He said he went to the closet to get the garbage bag which only took from 30 seconds to a minute, and when he turned around, he observed the resident falling out of bed onto the floor. He said there was a mat on the floor. He said he checked the resident. She was . . . . . , and he called for the nurse to come to check her. Staff A said that he was aware resident #4 was a 2-person assist. However, he was able to provide care to her alone. Staff A said he did not ensure that all the items needed were available before he began to provide care. He stated he should have had all the required items in place to provide care so that he would not have had to turn away. He further stated he learned from this, and now checks to make sure he has everything available. He said he received a training after the incident regarding . . . from a hospice representative. The hospital's admission/transfer noted that on , the resident arrived at the emergency department (ED). According to emergency medical services ( ), they were called because the patient out of bed, had a to the forehead, the left , the right . , and had a , ... The resident received 7 to her forehead. The resident was sent from the hospital to the inpatient hospice unit for continued care, where she . The ED work flowsheet noted the impression as: Acute four-centimeter . . . . . to forehead, Acute , rami and acetabular , Acute , . . hematoma, and Acute small . . . . . hematoma. The , report noted on , the resident . out of bed and sustained a . . The resident had	A 025		

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A 025	Continued From page 5 , , sustained an acute of the anterior column right acetabulum, a right pubic , and of the pubic symphysis with adjacent fluid collection possibly hematoma. A of the noted the resident from bed and had a "small amount of along the , aspect of the falx. Frontal , . Negative ." "A computed , , (CT or CAT) scan allows doctors to see inside your body." (www.webmd.com/ /what-is-a-ct-scan) The autopsy report, dated , revealed the resident on ; the cause of was blunt force injuries due to . According to documentation of a hospice assessment the resident required a two person assist. The resident was assisted with ADL care on by one staff. Staff A stepped away from the resident, the resident to the floor and sustained injuries. There was no documentation of an investigation of the conducted by the facility. The facility and hospice are to coordinate care for the resident's care. The resident was assessed to need two-person assistance with care. There was no training conducted after the resident's because the facility felt this was an accident. There was no training provided by the facility. The hospice agency provided a 1-hour training on titled " Prevention for elderly Population, which was eighty-six (86) days after the that occurred on . Residents under the care of Hospice are still the responsibility of the Assisted Living facility. There were no actions taken by the facility after the resident on , sustained injuries, and went to the hospital for acute care, and then	A 025		

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A 025	Continued From page 6 transferred to an inpatient hospice unit, where she . Class II	A 025		
CZ821 SS=C	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; and, (f) Approval of revisions to emergency management plans. (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	CZ821		

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CZ821	Continued From page 7 Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and availiable 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. 2. Assisted living facilities: a. Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 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 availiable 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. b. Liability claim reports required pursuant to section 429.23(5), F.S., and rule 58A-5.0242, F.A.C. 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 availiable at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse	CZ821		

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CZ821	Continued From page 8 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 availiable 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. (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 record reviews, autopsy report and interviews, the facility failed to electronically submit to the agency, a preliminary report within 1 business day and a full report within 15 days when 1 of 5 sampled residents (#4) was transferred from the facility to the hospital after sustaining a right , and injury. Findings:	CZ821		

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CZ821	Continued From page 9 Review of facility notes for resident #4 revealed on at 8:24 PM, the resident was found on a blue mat at the bedside. The resident sustained a to the forehead and left . The were cleaned, and applied. Facility notes revealed that on at 5:26 AM, the hospice nurse was in and sent resident out to the hospital for to the forehead at 1:30 AM. A note on at 10:41 AM reflected that the hospice nurse went to assess the resident. Resident #4 had a right , and to the forehead. Resident #4 was admitted to the hospice inpatient unit for , management. On at 11:00 AM, the Wellness Director said resident #4 , . She said staff a was providing care to the resident in her bed that had an air mattress, turned her on her, turned away to obtain something from the closet that was across from the bed, and when he turned around he observed her falling out of bed. She said the resident was sent to the emergency room and was later place in the hospice inpatient unit and she , . On , at 11:15 AM, the Administrator was asked if an adverse incident report was completed. The administrator said an adverse incident report was not completed because she was not aware that the facility was required to complete one because it was determined to be an accident. The Administrator and the wellness director were asked to provide documentation of their investigation regarding the incident. The Wellness	CZ821		

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CZ821	Continued From page 10 Director said she did complete an investigation but did not have documentation. On at 3:00 PM, staff A said he wheeled resident #4 into her room to provide care for her, placed her in her bed, raised the bed because it was in the low position, and removed her pants. He said he checked to determine if he needed to change her adult brief. He said he realized there was no garbage bag for him to put the adult brief into as they were in the closet. He said he lowered the bed, placed the resident on her side because she would move around sometimes in the bed. He thought she would be safer to turned onto her side for him to step away and get the garbage bag. He said he went to the closet to get the garbage bag which only took from 30 seconds to a minute, and when he turned around, he observed the resident falling out of bed onto the floor. He said there was a mat on the floor. He said he checked the resident. She was , and called for the nurse to come to check her. A review of the autopsy report dated revealed the resident , , on ; the cause of was blunt force injuries due to . Unclassified	CZ821		