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
	AL11969371	A. BUILDING: _____ B. WING _____	03/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERTUS MTD OPCO, LLC	4901 LAKE PARK CT MOUNT DORA, FL 32757

(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 complaint investigation (complaint number 2021004350) and a COVID-19 focused control survey was conducted at Certus MD OPCO, LLC on through . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=J	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 observation, interview and record review, the facility failed to provide personal supervision as appropriate to meet the needs for 2 of 3 sampled residents, Residents #1 and #2. Findings: Review of Resident #1's records revealed the resident was admitted to the facility on . The Resident Health Assessment for Assisted Living Facilities (Form 1823) revealed diagnosis that included with behavioral disturbance, and . His	A 025		

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A 025	Continued From page 2 /behavioral status was identified as with behavioral changes and special precautions included risk and elopement risk. Review of the facility progress notes for Resident #1 read, " , 06:37 [AM] Resident did not want to lay [sic] on his bed. He was going around the unit entering rooms. , 23:24 [11:24 PM] Resident out of bed at this time, pacing up and down hall assisted to bed 15 minutes prior, resident observed up pacing up and down hallway and in other residents' room. Redirection unsuccessful. , 00:56 [12:56 AM] Resident continues to set off all emergency exits. Redirection is provided consistently. Resident continues to pace hall. Attempted to redirect to bed unsuccessful. , 10:18 [AM] Resident attempting to enter other resident rooms ... seating at a table where other resident usually seats [sic] a close altercation with another resident." Review of Resident #2's medical records revealed the resident was admitted to the facility on . The Resident Health Assessment for Assisted Living Facilities (Form 1823) revealed diagnosis to include 's and Body (The second most common type of progressive after 's , may experience visual). His /behavioral status was identified as forgetful and restless at times. Special precautions included risk. Review of the physician visit notes for Resident #2 dated read, "New patient seen to establish care for multiple medical conditions. Per his wife he was living at home and ended up being by VA [Veterans Affairs] hospital due to attempt to kill his wife. He	A 025		

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A 025	Continued From page 3 was sent to a group home, then went to [Facility's name] where he got kicked out from due to aggressive behavior. He has a history of [illegible], Body with 's as well as [illegible] and per his wife he is easily triggered." Review of the facility progress notes for Resident #2 read, "[illegible], 15:40 [3:40 PM] Resident got up from his bed and proceeded to chase staff member out of his room. "I'm going to hit that _____ [expletive removed] because you [sic] black too" Staff member ran away from resident into the hallway and resident continued after staff member, another staff member step on [sic] front of resident for preventing [sic] him to get to [female staff's name] resident raised his [illegible] and hit staff member on his and arm. Everyone around walked away from resident and resident went to his room. Notify Primary Care Physician (PCP) and request order for an [sic] UA [illegible] r/o [to rule out] [illegible]. Medicated resident with [illegible] 0.5 mg [milligrams] as per order re: [regarding] agitation. DON [Director of Nursing], ED [Executive Director] aware of incident. DON called wife to made [sic] aware. [illegible], 08:39 [AM] Resident refusin [sic] care and refusing medications. Resident becoming combative tours [sic] staff when anybody [sic] enter his room. Made PCP aware this morning. [illegible], 07:28 [AM] Resident send to the hospital re (regarding) refusal to eat drink refusing care becoming combative tours [sic] staff while offering to provide personal care. [illegible], 15:32 [3:32 PM] Resident continue [sic] to refuse his medication this am [morning] took some of his med [sic]. Resident had cereal for breakfast. Unable to redirect resident when upset [sic] can get very aggressive at time when trying to redirect	A 025		

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A 025	Continued From page 4	A 025		

him. Will continue to monitor to ensure safety.
, 3:11 [PM] Resident OOB [out of bed] exit seeking observed resident observed [sic] holding the safety alarm on Meadowbrook until door opened, and [sic] began to walk toward the exit door by front desk. Redirection attempted 6 times finally successful. Resident also used foul language. Resident escorted to Meadow brook [sic], and appear to be
13:07 [1:07 PM] PRN [as needed] administered for agitation. Resident refused shower or to change clothing x [times] multiple attempts."

Review of Resident #2's clinical record read, " at 20:20 [8:20 PM] After eating dinner, resident asked writer to unlock his room door so that he could go to bed. Access to his private quarters were obtained. Resident went into his room, told the nurse goodnight and locked his door. Writer proceeded to complete med pass, make informative phone calls to family members and document incidents at this time. At approximately 7pm writer heard a resident yelling "Bitch! You came into my room, you came into my room." Once the origin of the yelling was known [Resident #2's name] was observed kicking [Resident #1's name] in the . Nurse called for help. Wellness staff members were providing care to fellow members of the community so a second call for help was made. Writer and wellness associates safely separated [Resident #2's name and Resident #1's name] while emergency services were contacted. Due to [Resident #2's name] current state and diagnosis of as well as [Resident #1's name] having physical altercations with other community members, concerns of an incident taking place with these two resident [sic] were commonly expressed."

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A 025	Continued From page 5 During an interview on at 2:17 PM, with Staff A, Wellness Supervisor, Licensed Practical Nurse (LPN), when asked regarding the altercation between Residents #1 and #2 on , she stated, "[Resident #2's name] had asked me to take him to his room. I had to unlock his room. When coming I saw [Resident #1's name] and I asked him if he was going to bed and he said yes. I was on a call with a family member when I heard the word, "bitch". I sat to listen in the nurse's stations then I heard, "Why are you in my room three times." Because I know how [Resident #2's name] is about people coming in his room. I got up and went into the hall. I saw [Resident #2's name] kicking [Resident #1's name] in the . When I called his name, his expression changed, and he [Resident #2's name] asked me why he [Resident #1's name] in [sic] my room three times. I said it is okay baby. You have to talk with him in a way so he will not be mad at me. I backed up into the hall and yelled for help. I did not have the phone. No one came, then one of the staff members, [Staff C's name] ran to me and I told him to get the phone. As I tried to summon [Resident #2's name] away from [Resident #1's name] and get him to sit in the chair outside the med room. I then went to [Resident #1's name]. [Staff C's name] stood next to him [Resident #2]. He kept stating he was coming to kill me. He was twice my size. [Resident #1's name] was not much bigger." When asked if Resident #2 had been aggressive in any other residents or staff? Staff A stated "Yes, he would have moments where he had moments and we knew to stay away from him." An interview was conducted on at 2:47 PM with Staff C, Wellness Associate, Medication	A 025		

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A 025	Continued From page 6 Technician. When asked about the incident with Resident #1 and Resident #2 on , he stated, I had gone on break and then I went to Meadowbrook [unit], the nurse was yelling asking for help. Me and my two coworkers went down and saw [Resident #1's name] lying in the front of [Resident #2's name] door. He was partially wrapped in [Resident #2's name] Ohio State blanket. [Resident #2's name] was still standing over [Resident #1's name]. [Resident #2's name] has a medical history of and he is used to seeing us in the green shirts, [has recognition of the green shirts worn by caregivers] when the nurse yelled his name we separated him from [Resident #1's name]. We sat him next to the nurses' station. [Emergency Medical Service] arrived to the facility. [Resident #2] asked for ice cream and so to keep him calm, we gave him ice cream. When asked if he had ever witnessed Resident #2 having aggressive behavior, he stated, "Yes, we had an incident where staff went into [Resident #2's name] room, it was probably in , 2020, and staff was running out and [Resident #2's name] was running after her. I came to help redirect and I tried to get his attention. I could not get his attention and kept calling his name and he slapped me." When asked when Resident #2 gets angry or aggressive, he stated, "Mostly when you try to enter his room." When asked if , behaviors around Resident #2 was safe, he stated, "No, we had issues with [Resident #1's name] going into other resident's rooms. [Resident #1's name] was moved to Meadowbrook [Resident #1 previously resided on Glenbrook, a unit on the opposite side of the facility]. We told the DON that it was not a good idea to move [Resident #1's name] over to the other side."	A 025		

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A 025	Continued From page 7 An interview was conducted on at 1:18 PM with Staff B, Wellness Associate. When asked about the incident with Resident #1 and Resident #2 on , she stated, "The nurse [Staff A's name] called me for help and I ran over. I saw [Resident #1's name] lying on the floor. [Resident #2's name] was standing right beside him. He [Resident #2] was done assaulting the resident when he saw our green shirts he calmed down. He [Resident #2] said, "I hope you're too, I hope you're ." We sat him [Resident #2] in a chair that is near the nursing station, we were cleaning his knuckles that were and . [Resident #2's name] was never aggressive to me physically. Sometimes he [Resident #2] will say when you take him his dinner to get out your trying to poison me. I will just leave and reapproach later. There was a problem with [Resident #1's name] when they moved him over to Meadowbrook from Glenbrook [unit]. We were afraid to have them [Resident #1 and Resident #2] on the same side and that we thought it would be a problem because [Resident #1's name] would try to grab people and kick people. During an interview on at 4:00 PM, Resident #2's PCP, Advanced Practice Registered Nurse (APRN), stated, "He is a very challenging resident for sure. I don't know if there is a facility out there that would be appropriate for him. We think that one of the triggers of his is entering the room. He does well with an appropriate approach. Only medical professionals go into his room. Yes, I believe the facility can keep his room locked but there are no guarantees." During an interview on at 11:06 AM, Resident #2's Mental Health Nurse	A 025		

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A 025	Continued From page 8 Practitioner stated, "He is not inappropriate but because of his he is going to see someone in his room to be a threat. Because the home is less restrictive and residents move around more, and if they cannot keep residents out of his room, he would not be appropriate. He cannot tell that it is not a threat. There is no guarantee. If a resident enters into his room, he will potentially see this as an ." During an interview, on at 9:14 AM, Staff D, Wellness Supervisor, LPN, stated, "He [Resident #2] was screaming on Sunday morning [ ], saying something in his room about getting his M16 to kill everyone. We opened the door and said his name and tell him he is not in the war anymore. And he calmed down. I gave him an after the episode to prevent any incident afterwards. I did not notify his APRN or the Psych APRN because his demeanor changed right away, but I still gave him an ." During an interview on beginning at 10:42 AM, the Wellness Director/DON, stated, "[Resident #2's name] was not following the incident on . He was already calm when the police officer arrived. There was an episode on when a staff member approached him [Resident #2] and went into his room, he stated, "don't come in", but she came in to assist anyway, and he said, "get out of here leave me alone". She left the room and closed the door. The resident came out and chased her. [Staff C's name] tried to intervene by stepping between resident [Resident #2] and staff. He [Staff C's name] was slapped." When asked if she was aware of Resident #2's behavior on Sunday, , she stated this incident was not reported to her and she had no knowledge of the behavior of looking for an M16 to kill everyone.	A 025		

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A 025	Continued From page 9 When asked if there was any service plan for Resident #2 or any interventions put into place following the incident on [redacted] she stated, "No." During an interview on [redacted] beginning at 11:52 AM, the Executive Director (ED) stated, "I found out that the resident [Resident #1's name] because the medical examiner sent a fax for more information and the wife [of Resident #1] sent a text message the next day [redacted] to inform us that he passed. We have not issued the resident [Resident #2] a 45-day discharge notice. In working with our corporation, we have evaluated his medications and he is being followed by psych services every week and that the trigger seemed to be that someone came in his room and took his blanket. Prior to the incident, his room was not locked, but is locked all the time now. After the incident [redacted], it's up in the air that whether he should stay here, and they are consulting with the corporate team. I feel that the measures that were put into place will keep the residents safe." Review of the facility investigation related to the incident dated [redacted] read, "Plan of Correction: 1. All resident room doors will be locked when residents are in their individual suites sleeping, resting, watching television etc. Residents can open their doors from the inside and come out of the room freely without any challenges as the locked door automatically unlocks when the door handle is pulled on to be opened. Any resident that desires to not have their room door closed and locked will have the right to keep their room door open and/or unlocked. However, this will be documented. 2. Staff will continue to knock on all residents' doors prior to entering and staff will announce themselves when entering a resident's	A 025		

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room. 3. Staff will continue to complete routine checks on residents. Staff will also check door handles to ensure room doors are locked. [Resident #2 name] room door will be checked hourly. 4. [Physician's Practice Name] and [Psych Services Name] will evaluate [Resident #2 name] weekly. 5. Staff will be educated on behaviors, and related behaviors. 6. [Resident #2 name] will continue to be encouraged to participate daily in engagement/activities to potentially assist with his triggers."

An interview was conducted with the ED on at 2:15 PM. When asked about the psych visits for Resident #2, she stated, "The weekly visits have not started yet. [name of company] will continue with bi-weekly visits and a psychologist from [name of company] will start and do biweekly visits. There are no audits to ensure and verify the resident doors are locked."

Record review revealed no audits to ensure all resident doors remained locked.

During an interview on beginning at 10:42 AM, the Wellness Director/DON, stated, "When [Resident #2's name] comes out of his room, we make sure it is locked, and we go with him to his room to make sure it is locked. He usually locks it himself. On the night of the incident, the door had to be unlocked as the other resident got into his room."

During an interview on at 9:14 AM, Staff D, Wellness Supervisor, LPN, stated, "We were told to minimize such incidents [ ]. We have to keep doors locked. They have to open it up for him [Resident #2] when he goes to his room."

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A 025	Continued From page 11 During an interview on at 9:29 AM, Staff E, Wellness Associate, CNA (Certified Nursing Assistant), stated, "I was on vacation, so I did not get the training that was offered after the incident. I have not received it as yet, and I returned from vacation on . . . . ." During an interview on . . . . . at 12:28 PM, Staff F, Wellness Associate, stated, "When I am assigned to him, I will check on his door every hour and then check on him every two hours visually. [Resident #2 name] locks his door when he leaves [his room]." During an interview on at 12:54 PM, Staff G, Wellness Associate, stated, "I will check his door every hour or hour and a half. [Resident #2 name] door is always locked. He locks it or tells you to lock it. Then he asks for someone to unlock it. We make sure his door is locked regardless." Review of the facility policy titled "Updated Community Policy" dated . . . . . read, "All resident suites are required to be locked when residents are in their individual suites while sleeping, resting, watching television, etc. Keeping the resident's suite doors locked while a resident is resting will assist with keeping . . . . . residents out of the resting resident's suite. Additionally, it is a resident's right to keep his or her door unlocked and open if it is the residents' request. It is a requirement to report to a Wellness Supervisor and/or supervisor the name and suite number of the resident who has requested to keep their door unlocked and/or open while they are resting or sleeping." Class I	A 025		

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A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969371	A. BUILDING: _____ B. WING _____	03/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 165	Continued From page 13	A 165		

incident, through the agency ' s online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident.
(4) Licensed facilities shall provide within 15 days, through the agency ' s online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident.

(6) , neglect, or , , must be reported to the Department of Children and Families as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief

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A 165	Continued From page 14 that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to report resident to resident to the Department of Children and Families (DCF) for 1 of 3 sampled residents, Resident #2. Findings: Review of Resident #2's clinical record reads, " at 20:20 [8:20 PM] After eating dinner, resident asked writer to unlock his room door so	A 165		

Agency for Health Care Administration

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A 165	Continued From page 15 that he could go to bed. Access to his private quarters were obtained. Resident went into his room, told the nurse goodnight and locked his door. Writer proceeded to complete med pass, make informative phone calls to family members and document incidents at this time. At approximately 7pm writer heard a resident yelling "Bitch! You came into my room, you came into my room." Once the origin of the yelling was known [Resident #2's name] was observed kicking [Resident #1's name] in the . . . . Nurse called for help. Wellness staff members were providing care to fellow members of the community so a second call for help was made. Writer and wellness associates safely separated [Resident #2's name and Resident #1's name] while emergency services were contacted. Due to [Resident #2's name] current state and diagnosis of . . as well as [Resident #1's name] having physical altercations with other community members, concerns of an incident taking place with these two resident [sic] were commonly expressed." During an interview on . . . . . at 11:02 AM, the Executive Director stated she did not notify DCF of the incident that occurred on . . . . . She stated she did not know she had to notify DCF. Class III	A 165		