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
	AL11911315	A. BUILDING: _____ B. WING _____	07/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT WOOD	1800 HARRISON STREET TITUSVILLE, FL 32780

(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 Complaint Investigation #2020019368 was conducted on [redacted] and [redacted]. Crescent Wood had a deficiency 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 shall 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] or [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 must notify the resident ' s representative or designee of the need for health care services and must assist in making [redacted] 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 59A-36.012, F.A.C.	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 (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 reviews and interviews, the facility failed to provide adequate supervision and failed to provide care and services appropriate to meet the needs to ensure safety through proactive measures to minimize the potential for and injuries for 1 of 4 sampled residents who experienced repeated . . (#1), and failed to follow a health care provider's medication order for 1 of 4 sampled residents (#4). Findings: 1. Resident #1's record revealed she was admitted to the facility on . A most recent 1823 health assessment form, dated . . . . . , indicated that her diagnoses included	A 025		

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A 025	Continued From page 2 ..... and ,, , that she was oriented to self only, and that she was a risk. The record contained additional 1823s that were dated , , and , all of which indicated she was either a risk or required precautions. Review of facility notes, facility reports and hospital documents revealed the following: On at 5:10 p.m., the resident yelled for help. She was found on her bathroom floor. She did not know how she . She landed on her and complained of , in her . She was not wearing socks or shoes; her walker was nearby, and she wore her call pendant. On at 6:02 p.m., she was found lying on her on her floor. She said she was coming out of her bathroom and tripped. Her left was visibly deformed, and she was yelling out in , . She was sent to the hospital. She was encouraged to use her pendant before getting out of bed or chair; staff were educated to keep her bed in the lowest position. On , a semi-electric bed was delivered for her. A hospital History and Physical (H&P), dated ....., indicated that she presented to the hospital following a , and an , revealed a left . She was hospitalized for repair of the . On , she returned to the facility from the hospital following surgery. On at 7:35 p.m., she was seen sitting on her floor between the couch and chair. She said	A 025		

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A 025	Continued From page 3 she was trying to sit in her chair and missed it. On . . . . . at 3:15 a.m., she was heard yelling from her room, and she was found on the floor by her recliner. She wore only socks; all the lights were off, and her room door was open. On at 6:35 p.m., she was up and about in her room using her walker. On . . . . . , a left , . , was done due to her complaints of left , , . On at 4:07 p.m., she was sent to the hospital due to a , ... seen on the , report. A hospital discharge summary, dated , revealed she presented to the hospital with left , , following a . An , revealed healing . . . . . of the left acetabulum and left . . pubic . On at 3 a.m., she was found on the floor of her room next to her couch. She said she tried to sit on the couch and missed it. Suggestions were made to her son that he provide a night light, non-skid socks, and a lower bed due to the resident stating the bed was too high. Her son was also educated on safety and prevention. On at 7:05 p.m., she was found on her bathroom floor . . . down. She complained of arm , and was sent to the hospital. A hospital H&P, dated , indicated she presented to the hospital with complaints of lower , following a . An , revealed a wedge , ... of both the fourth and fifth .	A 025		

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A 025	Continued From page 4 On at 6:21 p.m., she was found sitting on the floor in front of her couch. She said she was trying to get up on her own and go to the bathroom. She sustained a on her left arm. She wore non-skid socks and her pendant. On , non-skid strips were placed on her kitchen and bathroom floors for prevention. Her bathroom door was also removed, and she was encouraged to push her pendant. An of her , dated , indicated that she may have had an acute L2 , and an underlying was not excluded. On at 11:29 a.m., she was found on the floor in front of her couch. Her walker was nearby, and she wore shoes. She said she could not make it to the couch, and she attempted to get some coffee. She was encouraged to push her pendant. On at 11:50 p.m., a loud noise was heard. She was found lying on her on the floor in front of her bathroom. She said she slipped when she was walking to the bathroom. She sustained redness on her right . She was instructed to press her pendant for assistance. On , her son was asked to place a private sitter with the resident because she was on isolation for Covid and was at risk for while in her room during that time. Her son told the facility he had to think about it. Facility staff said they would increase checks on her. On , hospice was asked to provide a	A 025		

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A 025	Continued From page 5 private sitter due to the resident's isolation status and subsequent risk. Hospice advised that was not something they did. A request was made of the son again to provide one. Hospice provided a hospital bed and bed alarm. On at 5:29 p.m., she was found sitting on the floor in her room. She said she was trying to throw away a coffee filter when she lost her balance. She wore non-skid socks but not shoes. On , she was encouraged to use her pendant when in need of assistance. On at 5:30 a.m., she while on her way to the bathroom and landed on her . On , she was encouraged to press her pendant for assistance; her walker was next to her, and frequent checks were done on her. On at 4:40 p.m., she was found on the floor holding her in the facility's dining room. A large knot was seen on the of her . She said she did not know why she did it. She was sent to the hospital. A hospital H&P, dated , indicated she presented to the hospital with a following a . At , she was encouraged to press her pendant and frequent checks on her were ongoing. On at 9:04 a.m., she was found in her room on the floor in front of her recliner. She said she was trying to pick up something off the floor and when she tried to sit in the chair.	A 025		

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A 025	Continued From page 6 On , frequent checks were done. On , frequent checks were done. On at 1:38 p.m., she was found on her left side on her room floor. She said she dropped something and tripped. She sustained a cut on her right ring . On , physical and , were ordered. On at 6 p.m., a loud scream was heard. She was found on her bathroom floor between the toilet and shower. She said she lost her balance and . On at 9:52 a.m., she was seen on the toilet and was unresponsive. Both hospice and 911 were called. She was pronounced at the facility. Resident #1 suffered 15 between and , some of which resulted in injuries, including and . Facility documentation did not provide adequate supervision and did not implement sufficient interventions following each in order to minimize the potential for further . On at 1:45 p.m., the administrator confirmed the findings. 2. Resident #4's most recent 1823, dated , revealed diagnoses including , and ; it revealed she required assistance with self-administration of medications.	A 025		

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A 025	Continued From page 7 Resident #4's [redacted] Medication Observation Record (MOR) revealed an entry for [redacted] tablet 5-325 milligram (mg.) one tablet by [redacted] every six hours for [redacted]. The 12 a.m. dose on [redacted], [redacted] and [redacted] was not signed as given. Review of the [redacted] count sheet also was not signed as given on those dates. On [redacted] at 11:30 a.m., resident #4 said she could not recall whether she received the medication on those dates. On [redacted] at 12 p.m., the administrator confirmed the findings and was unable to provide additional documentation. Class II	A 025		