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 _____	07/15/2021

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 complaint investigation #2021004403 was conducted at Assisted Living on to . Deficiencies were identified at the time of 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) 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 reviews and interviews the facility failed to follow healthcare provider's order for medications for 1 of 4 sampled residents (#3) and failed to maintain written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention for 1 of 4 sampled residents (#2). Findings: Resident record review for resident #3 revealed a health Assessment report 1823 dated [redacted] listed diagnoses of [redacted], unsteady gait, [redacted], high [redacted], [redacted], retention, [redacted] of, [redacted] and	A 025		

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A 025	Continued From page 2 assistance was needed with self -administration of medications. The 1823 listed , 30 milligrams (mg) and , 20 mg daily among other medications. Fax from healthcare provider for visit dated listed , 10 milligrams (mg) 3 tabs daily , 20 mg take one daily 3350 one capful in water , 25 mg half-tab every 8 hours as needed , 500 mg every 8 hours Voltaren 2 mg gel 4 times daily one patch daily 1 tbs daily Change , every monthly and as needed The Medication Observation Record (MOR) listed , 30 mg take 1 tab daily, 40 mg was blank from to and marked given until , 10 mg take 3 tabs daily was marked as given on to 3350 take one capful cap in water, , 20 mg one daily, one daily was blank until , 5 mg daily was blank on and On the only medication marked as given was , 25 mg half tablet every 8 hours as needed. Health Assessment report dated listed transient , pancreatic /3 PS ankle the 1823 listed , 40 mg, , 5 mg daily and , 100 mg every 12 hours and , 40 mg daily.	A 025		

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A 025	Continued From page 3 Prescription order dated indicated discontinue , 100 mg, start , , 100 mg every 12 hours x 14 days -diagnosis right . The MOR listed , , 100 mg take 1 capsule every 12 hours for 14 days The MOR was blank from to at 8 AM. On at 8 PM and indicated and at 8 AM indicated hospital. The medication was marked as given on at 8 AM. The staff initials were circled on at 8 PM and at 8 AM, an indication the medication was not given those times. Prescription order dated indicated 500 mg ( ) at bedtime for , spasms, 800 mg twice a day for and , , 0.25 mg at bedtime, discontinue , 0.125 at bedtime. Start , 0.25 at bedtime, start DS twice a day for 14 days start 500 mg at bedtime. The MOR listed 500 mg at bedtime and , 0.25 at bedtime were blank from to , DS (SMZ/TMP) 800-160 was blank from to at 8 AM and had staff initials circled on in the AM and PM, , 0.25 at bedtime was blank from to . There were no written notations on the MOR or elsewhere that indicated why the medications not given, and notification to healthcare provider and/or resident representative. Facility notes indicated the following: The daughter was contacted to confirm pharmacy as per daughter, medications outside	A 025		

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A 025	Continued From page 4 of VA to be sent to the pharmacy used by the facility. The healthcare provider ordered to discontinue , 100 mg, start , , the daughter will pick up medication and drop off tomorrow. Continued review revealed no written notations that indicated that a follow up was done to ascertain whether the daughter dropped of the medications. In an interview with the Director of Nursing on at 11 AM who said the VA did not deliver on the weekends, the doctor and the resident's daughter were aware. The doctor worked at the VA clinic. The resident's doctor came to the facility on Fridays, so that created the same issue that medications would not be available until Monday. The facility did not have a system in place to confirm when medications were brought in by the family, they were simply given to the receptionist. The receptionist in turns called nursing to pick up the medications. For residents who self - administer, them the medications are given to them. As for the blanks on the MOR she did not have an explanation; she had taken her position not too long ago. Resident record review for resident #2 revealed a facility note dated that indicated the writer contacted the hospital about discharge planning. A note dated 7/82021 indicated the resident was getting a defibrillator placed. The continued review revealed no evidence to confirm what happened and why the resident was in the hospital and that the responsible party was notified. On at 3 PM the administrator provided a Leave of Absence (LOA) sheet dated	A 025		

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A 025	Continued From page 5 that indicated the resident went to hospital with , and returned . The LOA sheet is a document he uses to track when residents leave and return to the facility. he added that he took great responsibility for the care of the facility residents. Class III	A 025		