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
	AL11964507	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HOUSE	7999 SPYGLASS HILL ROAD VIERA, FL 32940

(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 re-licensure survey with Limited Nursing Services and Extended Congregate Care and a generator monitoring were conducted at Autumn House on [redacted]. Deficiencies were identified at the time of the visit.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician	A 010		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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
	AL11964507	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HOUSE	7999 SPYGLASS HILL ROAD VIERA, FL 32940

(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 010	Continued From page 1	A 010		

who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.
(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:
a. Move, turn, or reposition without total physical assistance;
b. Transfer to a chair or wheelchair without total physical assistance; or
c. Sit safely in a chair or wheelchair without personal assistance or a physical .
2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.
3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.
(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident ' s representative or designee or the resident ' s family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.
(3) A physician, physician assistant, or advanced practice registered nurse who is employed by an

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
	AL11964507	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HOUSE	7999 SPYGLASS HILL ROAD VIERA, FL 32940

(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 010	Continued From page 2 assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a [illegible]-to-[illegible] medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a [illegible] may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A [illegible] ill resident who no longer meets the criteria for continued residency may continue	A 010		

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
	AL11964507	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HOUSE	7999 SPYGLASS HILL ROAD VIERA, FL 32940

(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 010	Continued From page 3 to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility retained 1 of 3 sampled residents who developed an	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964507	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HOUSE	7999 SPYGLASS HILL ROAD VIERA, FL 32940

(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 010	Continued From page 4 , and thereby exceeded the continued residency criteria in an Assisted Living Facility (ALF) (#14.) failed to obtain a new 1823 health assessment form when 1 of 3 sampled residents experienced a significant change (#14) and failed to ensure an interdisciplinary care plan was developed and implemented for 1 of 3 sampled residents who received hospice services (#3.) Findings: 1. Review of resident #14's record revealed an admission date of and that her diagnoses included , , (,) , and Pre- . Two 1823 health assessment forms, one dated and the other , indicated the resident did not have any , . The record did not contain any other 1823's that were completed when the resident developed the , which was a significant change. A facility note that was dated indicated that a nurse noticed a , starting to develop on the resident's right heel. cream and a aid were applied. A note dated indicated the resident had a closed on her right heel that was mushy. A health care provider's (HCP) order that was dated instructed to apply skin prep to the right heel twice daily, , while in bed and slippers or open backed shoes when out of bed until the resolved. A Limited Nursing Service (LNS) nursing assessment that was dated indicated the	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964507	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HOUSE	7999 SPYGLASS HILL ROAD VIERA, FL 32940

(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 010	Continued From page 5 . . . . now appeared . . . . . and was mushy in the center but remained intact. A note that was dated indicated the right heel . . . . measured 2 cm x 2 cm, was black in color and had a mushy center but remained intact. A . . . . evaluation flow sheet that was dated indicated the was pressure related, was . . . . . and measured 3 cm x 3 cm. A HCP's order that was dated instructed to increase the application of the skin prep to the right heel to three times daily. A note that was dated indicated the . . . . was black, scabbed, and hard. The skin was intact without redness or drainage. A facility note that was dated indicated the . . . . was black and hard. A . . . . flow sheet that was dated . . . indicated the measured 3 cm x 3 cm and its status was unchanged. A flow sheet that was dated . . . . indicated the still measured 3 cm x 3 cm and remained unchanged. On . . . . . at 1:18 p.m. both the director of nursing (DON) and the surveyor looked at the . . . . . It measured approximately 4 cm x 4 cm and the bed was covered with 100% dry, black eschar. The resident's right lower extremity had 2+ . When asked how the occurred, the resident did not answer. The DON said it first presented as a and was initially	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964507	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HOUSE	7999 SPYGLASS HILL ROAD VIERA, FL 32940

(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 010	Continued From page 6 caused by a shoe rubbing on the heel. The resident was seen wearing socks with open backed slippers. Continued review of the resident's record revealed it did not contain any documentation to indicate the facility made any efforts to discharge the resident when the status of the became such that it exceeded the continued residency criteria. On at 2:15 p.m. the DON said the facility had not obtained a new 1823 when the developed and had not made any efforts to discharge the resident. 2. Review of resident #3's record revealed an admission date of . An 1823 that was dated indicated the resident received hospice services. Review of hospice records revealed the resident was admitted to services on . Continued review of the resident's record revealed it did not contain a plan of care which delineated how the facility and the hospice would meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. On at 2:15 p.m. the DON confirmed the findings and said she'd asked the hospice provider on two separate occasions to provide a plan of care. Class III	A 010		
AN278 SS=D	59A-36.022(3) FAC; 429.07 (3)(c)2, FS LNS - Records	AN278		

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
	AL11964507	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HOUSE	7999 SPYGLASS HILL ROAD VIERA, FL 32940

(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
AN278	Continued From page 7 59A-36.022 (3) RECORDS. (a) A record of all residents receiving limited nursing services and the type of services provided must be maintained at the facility. (b) Nursing progress notes must be maintained for each resident who receives limited nursing services. (c) A nursing assessment conducted at least monthly must be maintained on each resident who receives a limited nursing service. 429.07 (3)(c)2, FS A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services from the facility's staff. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure nursing progress notes were maintained for 1 of 3 sampled residents who received a Limited Nursing Service (LNS) (#3). Findings: Review of the facility's license revealed it contained an LNS designation. Review of resident #3's record revealed an admission date of . An admission note that was dated indicated the resident had multiple small on both arms. All were cleansed and	AN278		

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
	AL11964507	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HOUSE	7999 SPYGLASS HILL ROAD VIERA, FL 32940

(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
AN278	Continued From page 8 Xeroform and were applied. A note that was dated indicated two small remained on the resident's right . They were cleansed and covered with Xeroform and . Review of the resident's medication record revealed an entry to cleanse on arms, apply Xeroform and every three days, which was an LNS. The treatment was signed on , , , and . However, continued review of the resident's record revealed it did not contain nursing progress notes for each time the treatment was performed. On at 1:25 p.m. the Director of Nursing (DON) confirmed the findings and was unable to provide additional documentation. Class III	AN278		