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
	AL11953416	A. BUILDING: _____ B. WING _____	09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA MANOR INC.	926 S. MYRTLE AVENUE CLEARWATER, FL 34616

(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 (# 2021009593) in conjunction with a generator monitoring survey was conducted at Magnolia Manor Assisted Living Facility on [redacted] and [redacted]. 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 [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	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 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 record review and interviews, the facility failed to provide personal supervision and be aware of the general health and safety after a rehabilitation stay and risk of of 1 (Resident #1) of 1 resident sampled. Additionally, the facility failed to maintain a written record of significant changes in health for one (Resident #1) of one resident sampled. Findings included: A further review of Resident #1's record conducted on revealed was and required assistance with all	A 025		

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A 025	Continued From page 2 Activities of Daily Living (ADL's) with the exception of eating. Resident #1 required the use of a wheelchair for transportation/ambulation. A review of Resident #1's record conducted on revealed he was admitted to the facility on with diagnosis that included , , decreased mobility and history of . An interview was conducted with Resident #1's Power of Attorney (POA) on at 12: 52 PM. During this interview the POA stated," [...] on that Friday ( ) he while in the shower and crawled himself to bed. He told me that he was telling staff his , was hurting all weekend [...] but no one said anything to him. The staff just brought him his meal every day and he said that he always complained about mild , related to his , , so he guesses they never thought anything about it. On Tuesday ( ) when his home health Physical , ( ) person came that's when they found out he had . The said that he was lying in bed with his going the opposite direction and blatantly obvious that something was wrong." An interview was conducted with Resident #1 on at 12:21 PM. During this interview Resident #1 stated," On that Friday ( ) I had a shower chair in the shower. It was new [...] I went to get into the shower chair and slipped. I was just hanging on the side of the chair. I made it to my bed. I was in bed for the weekend. I laid in bed and couldn't even roll over. Hell yeah, I was in , . My damn was poking out from , . You could see it. It was purple. I told everyone who came into my room that I was in , . This home health nurse came after the weekend and saw me. She is the one that told	A 025		

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A 025	Continued From page 3 the boss lady (Assistant Administrator) about my condition , that I was in , and needed to go to the ER (emergency room)." A record review was conducted on revealed the following observation note submitted by the Assistant Administrator (AA): * : Resident returned from rehab (after having surgery on his left on) with orders for , and ST (, ,) * : (, ,) came to see resident (Resident #1) and found his left , area bulging but different than right , . He told that on Friday evening /night he gently in his shower . * : Sent daughter (POA) a message to tell her dad went to ER . The chart review revealed no evidence of an adverse incident report, report or investigation related to this incident. A attempted record review of the facility's policy and procedures revealed no evidence of a " Protocol" or any employee in-services related to this incident. During an interview with the Assistant Administrator on at 11:49 AM. During this interview the Assistant Administrator stated that she is responsible for all of the documentation. She stated that if there is a the staff call her, and she completes an incident report. She further stated that if a resident is not in , or complaining of that they are hurt they do not send them to the Emergency Room. She contacts the Administrator if a resident may have	A 025		

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A 025	Continued From page 4 to go out since he is a Registered Nurse and follows his directions. Lastly, she stated "[...] I really don't document the or keep track of those things. Maybe I should start doing that. No, I don't think we have had any adverse incidents reports." An interview was conducted on at 12:21PM with Resident #1, he stated he had on Friday ( ) when he went to get into his shower chair. He made it to his bed and laid in bed all weekend. He stated he was in , and his was poking out from his , and it was purple. Resident #1 stated that he told the staff he was in , . An interview was conducted with Staff A on at 1:16PM, she stated that Resident #1 was always requesting , medication prior to his surgery. She stated that Resident #1 was in his room the entire time after he returned from his surgery, and he was constantly asking for , medications. An additional interview was conducted with the Assistant Administrator on at 1:37 PM. During this interview the Assistant Administrator confirmed that Resident #1 was sent to the Emergency Room and stated," so all I know is when the came to do his , , , she noticed that his wasn't facing right. She came told me, So I went down to talk to him I saw the and it was going the other way. I asked him what happened he said he " An interview was conducted with the Owner/Administrator on at 1:47PM, he stated that staff informed him that Resident #1	A 025		

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A 025	Continued From page 5 had [redacted] on Monday ([redacted]). The Owner/Administrator stated that he assessed Resident #1 and there was nothing wrong with him. The Owner could not produce any evidence of the assessment that he had conducted on Resident #1. Class II	A 025		