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
	AL11953542	A. BUILDING: _____ B. WING _____	R 09/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMS OF LONGWOOD (THE)	480 EAST CHURCH AVENUE LONGWOOD, FL 32750

(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 Revisit to Complaint Investigation #2021007444 was conducted on 9/12/21 and 9/16/21. Palms of Longwood, LLC, had uncorrected deficiencies found at the time of the visit.	{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) Monitoring of the quantity and quality of resident diets in accordance with rule	{A 025}		

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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: DEFICIENCY REMAINED UNCORRECTED Based on record reviews and interviews, the facility failed to assess appropriately and for changes in condition for 1 of 21 sampled residents (#16), failed to prevent the development of , . . for 1 of 21 sampled residents (#16), failed to follow a health care provider's order for 2 of 21 sampled residents (#4 & #10), failed to obtain orders for . . and . . . monitoring from a health care provider for 2 of 21 sampled residents (#1 & 29), failed to ensure physician medication orders were followed and prescribed medications refilled timely as ordered for 2 of 21 sampled residents	{A 025}		

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{A 025}	Continued From page 2 (#6 & 24), and failed to notify health care providers and responsible parties and document in 13 of 21 sampled resident's records when , hospitalizations or changes in health status occurred. (#2, 3, 7, 8, 9, 12, 14, 15, 16, 22, 30, 31 & 32). Findings: 1. Resident #16's record revealed a facility admission date of . An undated 1823 assessment form indicated the resident's diagnoses was with . The resident's was not documented on the form. He was a resident in the Memory Care unit. His medications included , (), Donezepil (for mild to moderate), and (for moderate to severe 's type). A note, dated , revealed documentation that the resident's grooming was moderately kept; he was well-nourished and well-developed. A hospital visit summary, dated , indicated the resident's (lb.) A hospital prescription, dated , indicated his . Review of a fire department response report, dated , revealed documentation that they were dispatched to the facility for a man who was not eating. They found that resident #16 appeared to be and was lying in the position on a bed. He was filthy, the room was 90+ degrees, the air conditioner was unplugged, he was wearing pants that were	{A 025}		

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{A 025}	Continued From page 3 soiled, and was lying on a soiled mattress with no sheets. On the bedside table was a foam cup that contained mold on top of a drink. There was a dresser in the corner of the room with an old sandwich with one bite gone from it sitting on top. The rest of the room was empty. He had a weak and fast radial , ... The facility stated the resident was last seen normal 3 weeks ago and could not advise when they had checked on him last prior to calling 911. He had a history of being combative but was so weak and frail that he could barely roll over. He smelled of feces and his pants were dry, but . . . . stained. He remained responsive to , , would localize the , and be agitated with any touch. Review of a law enforcement report, dated , revealed documentation that on . . . . . at approximately 3:56 p.m., an officer was dispatched to the facility. Upon entering, resident #16's room, an acrid odor of . . . . and feces was smelled. There was dried . . . and feces strewn about the floor. An adult diaper was discarded in a corner of the room behind a dresser. An old, stale, partially eaten sandwich was atop a dresser. A food cart in the room had a cup on it that appeared to contain juice with mold floating on the surface. The bed had no linens or bedspread on it. There was no clothing present in the room. Feces covered the bathroom floor and toilet seat. A police investigator was notified and subsequently responded to the scene. Review of an emergency department (ED) history and physical (H&P), dated . . . . . , revealed documentation that indicated the chief complaint was . . . . . Resident #16 presented with . . . . . to the penis and . . . . . stage one to two , , ... He was in acute distress, ill-appearing, had dry	{A 025}		

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{A 025}	Continued From page 4 and , distress was present. The resident's , were open, he withdrew to , and moaned but did not say words. The clinical impressions were , acute , injury, severe , Covid-19 , and with behavioral disturbance. He presented to the emergency department with a , of , , , , rate of 28 and he tested positive for Covid-19. Review of an internal medicine H&P, dated , revealed documentation that indicated the resident was and , . This was an loss since . The resident's record did not contain any facility documentation to indicate the resident was sent to the hospital and that a health care provider and responsible party were notified when he was sent. Advanced Practice Registered Nurse (APRN) Z's visit note, dated , revealed documentation that the resident's diagnoses was with Behavioral Disturbance, , and Abnormal Gait and Mobility. The resident was pleasant, repeated himself a lot and was , . He was ungroomed. He reported regarding cars and people stealing things. There were boxes of old food in his room. He said he was fine and had no complaints. He reported that his appetite was good. A physical exam revealed he was well nourished. His skin was warm and dry to touch with no or . The APRN's plan of care at that time was to continue medication as prescribed, and encourage the resident to engage in community activities. She instructed nursing staff to call the physician's	{A 025}		

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{A 025}	Continued From page 5	{A 025}		

office if they had any questions or concerns, and to call if the resident complained of , or . The APRN said she was never told that the resident had a decline. Eight days after the APRN examined the resident, he was sent to the hospital, where his body was documented as . His was documented from a previous hospital visit as ., an eight-one (81) , loss. The APRN never addressed this extrememly significant loss.

On at 12:54 p.m., staff R said resident #16 went to the hospital on . She could not recall any details and said she never saw any on him. He allowed staff to help him off and on. He always ate in his room. A day or two before he went to the hospital, he allowed her and staff P to change him, change his bed and give him something to drink. Food was oftentimes left in his room; he usually removed the linen from his bed, and he yelled and threw things. He on his bed and the staff were not able to do anything with him. Staff R said she told staff L about the resident's behaviors and challenges in caring for him.

On at 1 p.m., staff P said resident #16 was aggressive at times since she began her employment in , . At times, he allowed staff to provide him with care, give him a bed bath and change his clothes. She did not see any on him. It took two to three people at a time to provide care to him due to his aggressive behavior. He broke his air conditiioner. She said she told staff L, the previous administrator, about the resident's condition and behaviors, but nothing was done.

On at 1:14 p.m., staff S said staff were

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{A 025}	Continued From page 6 unable to properly care for resident #16 due to his aggression. On , he allowed her and staff P to clean his room, bathe him and change his clothes. On approximately , staff S returned to work after having had time off and she noticed the resident had a decline. He always complained of not wanting food, but he did drink well. On approximately , he was not getting out of bed, so she told staff L but, nothing was done about it. He would not allow people to enter his room. There was and in the room because staff could not go in to clean it. She told the previous administrator, staff L, who ignored her. When 911 personnel rolled the resident over on , staff S saw redness on the resident's right , . On at 9:35 a.m., staff B said she and the facility's owner were doing rounds together on . When they looked into resident #16's room, staff B saw the resident lying in bed in a position. He was boney and not moving. He opened his , but was not responsive. She said the resident normally did everything for himself. He had previously not allowed staff to come into his room and had been combative and violent, but not on . On at 12:47 p.m., staff G said resident #16 did not eat well but drank juice and ate ice cream. He was sleeping a lot but told her to get out of his room. He would not let her remove old food from his room or clean him up. When she last saw the resident on , he verbally responded to her and told her to get out of his room. On at 12:57 p.m., APRN Z said resident #16 ate only a little bit. He did not want staff to go into his room. She said she was never told that	{A 025}		

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{A 025}	Continued From page 7	{A 025}		

he had a decline and that he became unresponsive and was sent to the hospital. She did not say the resident required any care for his behavior of refsuing care and not eating.

On at 10:49 a.m., staff L said resident #16 destroyed his room and would not let staff in to clean his room or to shower him. She tried to find him somewhere else to go but no one would take him. She believed the business office manager at the time issued the resident a 45-day discharge notice, but staff L did not know where a copy of the notice could be in the facility. She did not know the resident's health status because there were Covid positive residents on the memory care unit and she did not go up there to see him. She said no one told her that he declined or what his condition was prior to him going to the hospital. She said in the past, they all knew he needed to go somewhere else.

On at 12:37 p.m., resident #16's sibling said he was the resident's POA. He last saw the resident in the facility either at the end of or the beginning of . . After that, the facility stopped allowing visitors due to Covid. He said during that visit, the resident was clean and his room was clean. He said the resident was ornery and he told the facility staff they could give the resident a if he needed it. He said no one from the facility ever called him to discuss the resident's behavior or to tell him the resident wasn't eating. He said he spoke with the previous administrator, staff L on multiple occasions, but she only talked about money, and she never told him that the resident was declining. He said the facility never gave him a 45-day discharge notice for the resident. He said the resident had always been skinny but estimated the resident's to be . when he last visited the resident in ,

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{A 025}	Continued From page 8 2021. He said when the resident arrived at the hospital, he was covered in feces and and . He learned the resident was in the hospital when he received a call from a hospital nurse telling him the resident was there. On at 12:28 p.m., staff A said after resident #16 was sent to the hospital, she spoke with staff regarding protocols. Specifically, to check on the cleanliness of residents' rooms, make sure residents were alive, and that no residents or were on the floor, and to notify administrative staff if a resident refused care. She also said that she, staff T and staff C began checking on every resident every morning at 9 a.m., then met afterwards to discuss any resident who required additional assistance or any who had a change in condition. On at 12:57 p.m., staff H, who worked 11 PM-7 AM on , said she opened resident #16's room door and looked in on him every two hours. She said each time she did, he was sleeping on his side and did not appear to be in destress. She said he wore pants only. She said he usually slept through the night when she worked. On at 1:03 p.m., staff R, who worked PM on , said whenever she went into resident #16's room he was lying in the bed and was alert and talking. She said he drank juice and took his medications. She said he did not eat well. There was no documentation that staff contacted the physician for resident #16's declining health. At that time, the fqacility was staffed with only one unlicnesed staff, who said they reported their concerns to the previous administrator, who did nothing about it. The phsyciain was never contacted about	{A 025}		

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{A 025}	Continued From page 9 resident#16's declining health. On ... at 1:06 p.m., staff P, who worked 7 AM-11 PM on , said when she checked on resident #16, he was in his bed. He was alert and talking. She said he played with his food and ate approximately .% of his meals. He did not allow her to go in his room to clean either him or the . . Review of resident #14's record revealed a facility admission date of . An 1823 assessment, dated ..., revealed the resident's diagnoses included , , Insufficiency, , and Valve , . On at 1 p.m., staff P said came to check on the resident who was coughing, had a . and was . Staff P said the nurse sent the resident to the hospital approximately three to four days after telling staff L, the previous administrator, about the resident's condition. The resident's record did not contain any facility documentation to indicate the resident ever had a change in her condition or that she was sent to the hospital. On at 1:14 p.m., staff S said resident #14 tested positive for Covid-19. The resident was coughing and had a runny . Staff S said she told staff L that resident #14 was sick and, in the bed, but the previous administrator never went to see the resident. On ... at 12:57 p.m., APRN Z said she ordered staff to monitor resident #14's level and to notify the APRN if the resident had a change in condition. Approximately ten days later,	{A 025}		

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{A 025}	Continued From page 10 she saw the resident and told staff L to send the resident to the hospital. The next day she saw the resident was still in the facility, so she asked staff L why and staff L, who acted surprised by that information, said she told the staff on the day before to send the resident to the hospital. The APRN said the facility lost the resident's orders and the previously ordered work was not done. The APRN visit note, dated , indicated the chief complaint was that the resident tested positive for Covid-19 on that day. The APRN ordered C, and D, for 10 days, monitor saturations twice a day, and call the health care provider if the resident's condition declined or worsened, and to make sure the resident sat up most of the day to prevent . The APRN visit note, dated , indicated the chief complaint was the facility staff were concerned about the resident's saturation level of 93%. An exam revealed an level of 95%. The APRN ordered a , sit the resident up most of the day to prevent , and monitor the resident's saturation twice a day. The APRN visit note, dated , indicated the resident was not eating good, was not responding to her name or simple commands. The resident had a loss of alertness and . The resident was lying in bed and had not been up despite orders being written over ten days prior to sit her up most of the day. A , (), complete profile (CMP) and were ordered on ago but were not done. The APRN was not notified of the resident's decline. There had not	{A 025}		

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{A 025}	Continued From page 11 been a nurse in the building in about two weeks. The APRN notified staff L at the time of the orders not being done and told staff L and a medication technician (med tech) to send the resident to the hospital as soon as possible on that day, [redacted]. The APRN visit note, dated [redacted], indicated the resident was still at the facility and did not go to the hospital the day before, despite orders to do so. The medication technician and staff L were told again to send the resident to the hospital. The APRN asked staff L why the resident wasn't sent to the hospital. The resident's [redacted] saturation was 90%, she had [redacted], and was not responding to simple commands. The resident was sent to the hospital on [redacted]. On [redacted] at 10:49 a.m., staff L said she told staff several times to send resident #14 to the hospital because the resident had Covid-19. Staff L could not remember who the staff were that she told. She said she did not go to the unit herself to check on the resident's condition. She could not remember specific dates then said she believed it may have been that she told staff to send the resident to the hospital. She said she thought APRN Z told her to send the resident to the hospital on [redacted], but on [redacted] the resident was still in the facility and the APRN went to staff L upset. On [redacted] at 4:30 p.m., staff C said resident #14 tested positive for Covid-19 while at the facility but she could not provide any test results. On [redacted] at 12:28 p.m., staff A said she was present on when APRN Z spoke with staff L about why resident #14 was not sent to the hospital as instructed on . Staff A said	{A 025}		

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{A 025}	Continued From page 12	{A 025}		

nothing was done by the facility to prevent that occurrence from happening again.

On at 12:45 p.m., staff L, the previous administrator, said APRN Z told her work, and a , were not done for resident #14, as the APRN had ordered. Staff L said she put labeled boxes in the nurses' station to place orders so they would not be missed. Staff L said she did nothing to prevent future occurrences of residents not being sent to the hospital when a health care provider ordered it because she was sick herself, and conducted a zoom meeting with staff. She could not recall which staff attended and what topics were discussed during the meeting.

A hospital critical care medicine H&P, dated , indicated the resident presented to the hospital on in , distress. On arrival, the resident had reduced alertness, and responsive. Her , rate was in the 40s and saturation was 90%. She was emergently intubated for acute , failure. She tested positive for Covid-19 and had severe electrolyte abnormalities. Her admitting diagnoses included acute respiratory failure with hypoxemia (saturation 90% on 5 liters per minute), , acute , severe electrolyte imbalance with 166 (high), and acute , injury She at the hospital on .

3. Resident #4's record revealed a facility admission date of . An 1823 assessment, dated , indicated the resident's diagnoses were , , , , and . She

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(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 025}	Continued From page 13 required assistance with self-administration of medications. The health care provider prescribed [redacted] ([redacted]) 20 milligrams (mg.) by [redacted] twice daily for fifteen days (to treat/prevent [redacted]) and [redacted] ([redacted]) 4 mg. by [redacted] every six hours for five days on [redacted] (to prevent [redacted] & [redacted]). The resident's [redacted] Medication Observation Record (MOR) revealed neither medication was listed. On [redacted] at 10:08 a.m., resident #4 said she recalled going to the hospital where she was given a prescription for [redacted] and [redacted]. She said the facility staff told her they had to wait a couple of days to receive both medications. She thought she may have received one dose of [redacted]. On [redacted] at 2:30 p.m., staff C said she called the pharmacy and was told [redacted] and were both previously delivered to the facility. On [redacted] at 2:40 p.m., staff D removed resident #4's package of [redacted] that was stored with another resident's medications. The date on the prescription label was [redacted]. Twenty tablets were dispensed, and twenty tablets were still in the package. Two packages of the [redacted] were stored with resident #4's medications. The date on the label was [redacted]. Thirty tablets were dispensed, and eighteen tablets remained. Based on the number of tablets that remained, the resident did not receive the medication twice daily as prescribed. Staff D said he gave [redacted] each morning he worked but he could not sign the MOR because an entry for the [redacted] was not on it. Staff C said only the pharmacy had access to make changes to the electronic MOR. 4. Resident #1's record revealed a health	{A 025}		

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{A 025}	Continued From page 14 assessment, dated [redacted], which listed diagnoses of an Advanced [redacted]'s, and Type 2 [redacted]. He had slow cognition. He needed assistance with self-administration of medications. A health assessment, dated [redacted], listed diagnoses of [redacted], [redacted] ([redacted]). He was forgetful and was a [redacted] risk. He needed assistance with all activities of daily living and medications. ED discharge paperwork, dated [redacted], listed diagnosis of [redacted]. Hospital discharge paperwork, dated [redacted], indicated diagnosis of [redacted] to Left [redacted] Wall, Right Great [redacted] and [redacted] Wall [redacted], and Strain to Left [redacted]. The resident's record did not contain any written notations that there was a significant change in the resident's health status that required an ED visit. There was no evidence the resident's responsible party and healthcare provider were contacted. The following prescriptions were seen in the record: [redacted] 30 units (u.) in AM and 25 u. in PM; [redacted] ([redacted]) 500 mg. four times a day for 7 days, [redacted] 20 u. every day and [redacted] (for [redacted]) 500 mg. twice daily; [redacted], [redacted] powder twice daily; Discontinue [redacted] and change to [redacted] ([redacted]) to 25 mg. daily. The prescription dated [redacted] was from the local ER and indicated he was examined and treated. His record did not contain any written notations of significant changes in the resident's health status on [redacted] that required an ER visit. There was no evidence the resident's responsible party and healthcare provider were	{A 025}		

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{A 025}	Continued From page 15 contacted. The [illegible] MOR listed the following: [illegible] 20 u. once daily had a letter "X" from [illegible] to [illegible]. Staff initials were circled on [illegible] and [illegible] and indicated change in direction. [illegible] 500 mg. twice daily at 7 AM and 7 PM was blank from [illegible] to [illegible] at 7 AM. [illegible] powder to affected area twice daily at 7 AM and 7 PM was blank from [illegible] to [illegible] at 7 AM. [illegible] test strips every morning were marked as done [illegible] and from [illegible] to [illegible] however the results were not documented on the MOR. The review revealed no evidence to confirm that there was an order for changes made to [illegible]. There were no explanations why [illegible] and [illegible] were started 8 days after prescribed. There was no evidence of a healthcare provider's order for [illegible] testing. The [illegible] MOR listed the following: [illegible] test strips every morning was marked as done every day at 8 AM, however the actual results were not listed but staff initials were documented. The medication notes in the MOR indicated on [illegible] at 3 PM, the resident was admitted to the hospital and continued to indicate hospitalization on [illegible] at 4 PM. On [illegible] at 7 and 8 PM, the MOR indicated "resident moved out [illegible] at 8 PM. On [illegible], [illegible] and [illegible] D was marked as "completed order". On [illegible] at 7 AM, 11 AM, 3 PM, 4 PM, 7 and 8 PM "resident was hospitalized" but on [illegible] at 8 AM, it indicated that [illegible] was held per nurse	{A 025}		

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{A 025}	Continued From page 16	{A 025}		

practitioner for low . test strips to test as needed was blank from to .

Record review revealed the resident did not move out of the facility. There were no written notations that documented what changes took place regarding the resident's health status that required hospitalization, and for how long. There was no evidence that a healthcare provider ordered to hold for "low ".

The MOR listed the following:
at 8 AM. was held
" was low".
at 8 AM. not given,
low.
at 8 AM. 70/ 30 was held,
was 67.
and , 70/ 30
was blank at 4 PM.
test strips every morning was marked as done every day at 8 AM. Actual results were not listed but staff initials were documented.

The resident's ER record revealed the resident's wife took him to the local ER on because the resident complained of right and , . The resident and did not tell the facility staff. The final diagnosis was closed non-displaced of the right ring and right little . The treatment done was placement of an gutter ., and referral to a , .

On at 12:50 PM, caregiver D said resident #1 had a and hurt his arm. He came from the hospital with his arm wrapped, but there was no . The resident was not getting becasue it had been

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{A 025}	Continued From page 17 discontinued. On [redacted] at 3:30 PM, caregiver F said the resident's [redacted] was discontinued. On [redacted] at 11 AM, Resident Care Coordinator said the resident went to the ER because he had a change in mentation; he had a [redacted] and returned the same day. He went to the ER again on [redacted] and returned on [redacted] due to a [redacted], and had a [redacted]. She was unable to locate any facility notes and an order for [redacted] testing. On [redacted] at 11:30 AM, the interim executive director said she had spoken with the resident's healthcare provider and pharmacy who both confirmed the [redacted] was not discontinued. She added the resident would not be unable to self-administer [redacted]. The resident's record did not contain any no written evidence that the resident went to the ER and had returned to the facility with his right [redacted] "wrapped". 5. Resident #22's health assessment, dated [redacted], listed diagnosis of [redacted]. A hospital discharge summary indicated the resident was hospitalized from [redacted] to [redacted] due to [redacted]. There were no facility notes regarding the change of health status that the resident was hospitalized, and no communication with the resident's responsible party. On [redacted] at 11:30 AM, the resident care coordinator said she had no additional information to provide. 6. Resident #29's health assessment report, dated [redacted]/20219, listed diagnosis of	{A 025}		

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{A 025}	Continued From page 18 type II and was mentally . . . . According to the assessment, he needed assistance with self-administration of medications. The . . . . . MOR listed " . . . . . stick" at 8 AM, 11 AM, and 4 PM and were documented as done from . . . . at 8 AM to at 11 AM; at 8 AM to . at 4 PM, . . at 8 AM, 11 AM and 4 PM, ... at 8 AM and 4 PM, at 8 AM 10 at 11 AM . . . . at 8 AM to . . . . . at 11 AM, and from PM to at 4 PM. The . MOR listed " . . . stick" at 8 AM, 11 AM, and 4 PM, and was marked as done from at 8 AM to at 11 AM, ... at 4 PM to . . . . at 11 AM. The review revealed no evidence to confirm that a healthcare provider order was available for the . . . . . testing. On . . . . . at 11:30 AM, the Resident Care Coordinator said she had no additional information to provide, there was no order for . . . . testing. 7. Resident #9's record revealed a history and physical, dated . . . . . from a rehabilitation center, that noted the resident was had and . . , . . , and was treated with an . . . . . . He was discharged to another rehabilitation center on . . . . . and was discharged . . . to the facility on . . . . . A facility note, dated . . . at 1:15 PM, reflected that the administrator documented the resident returned from rehabilitation center on . . . . . There was no documentation to confirm why the resident was admitted to the rehabilitation center and that the family and health care provider were contacted to inform them.	{A 025}		

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{A 025}	Continued From page 19 The marketing director confirmed the findings on at 3 PM. She said there were no other notes available. She was not aware of the requirement to maintain documentation of when there were hospital admissions, and to document when the family and health care provider were contacted. 8. Resident #10's MOR for , , and revealed Solorstar 25 u. every evening. The MOR reflected that unlicensed staff initialed the MOR as giving the medication at 4 PM. The label on the , revealed read to inject 25 u. , (sc) every night at bedtime. An order dated noted sc 25 u. at bedtime. On at 3:30 PM, staff D was observed taking the resident's level and documented it on a paper that was personally his, the result was 421. He then placed the needle on the , and instructed resident #10 on how to use it. Staff D had to tell the resident to press the pen down on his to inject the . Staff D said resident #10 was not capable of doing his own without assistance. Staff D said he would take the resident's before providing the , but there were no orders for it. He said he would do it on his own. He said the resident's were high because he would drink a lot of soda. He further stated he would assist with the at 3:30-4 PM instead of bedtime as ordered, because the previous administrator instructed the staff not to give the at bedtime because there would not be anyone there to do it. On at 9:45 AM, a telephone call was	{A 025}		

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{A 025}	Continued From page 20 made to the health care provider who was listed in the resident's chart to clarify the time the resident's [illegible] was to be given and if a nurse was required. The health care provider said he no longer provided care to the residents of the facility. He said the previous administrator would not allow him to do what he needed to do for the residents, refused to allow him to review the resident's medication, and told him it was a HIPPA violation even though he was the resident's doctor. He said he gave a 30-day notice to his patients there because of the multiple problems at the facility. On [illegible] at 10 AM, the marketing director who was in charge said resident #10 did have a new health care provider because his previous doctor did not provide care to the residents of the facility because of the previous administrator. A physician's order from the new health care provider, dated [illegible], noted to monitor [illegible] 3 times with meals and Regular [illegible], continue [illegible] 20 u. daily, obtain hemoglobin A1c (HbA1c) (measures the amount of [illegible] attached to hemoglobin, [illegible] ([illegible]) [illegible] / [illegible] ratio (estimates 24-hour [illegible]), complete [illegible] profile (CMP) and follow up in 1 month. The resident's record did not contain any documentation that labs were done, that the resident's [illegible] was obtained 3 times daily, and that the resident received Regular [illegible] on a [illegible]. There was no documentation to confirm that the resident's high [illegible] results were reported to the health care provider.	{A 025}		

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{A 025}	Continued From page 21 The facility staff was given the opportunity to provide clarification orders for the , when the regular was to be provided to resident #10, and the amount. The documentation was not provided. The staff was not aware of the new orders provided by the health care provider. 9. Facility notes on 2 /23/2021 reflected that it was reported to the Resident Care Director by the overnight medication technician (med tech) that resident #12 was found on the floor by laundry room. The med tech took resident's , . It was . The Resident Care Director advised the med tech to call emergency medical services ( ) and have resident transferred to the ER. transferred the resident to the hospital. On at 2 PM, the resident returned to the facility. There was no documentation that the health care provider and family were contacted regarding the hospital admission There was a hospital discharge note, dated , but no facility note regarding what had occurred that required the resident to be sent to the hospital, and no facility note that the family and health care provider were contacted. Facility notes reflected the following: at 9:15 AM - "Late Entry at 8:40 AM. Writer to resident's room for AM . Upon arrival writer notes increase , dark in FC [,] bedside drainage bag, resident alert to person. [level] obtained at 188. Resident states "I just didn't sleep well last night" writer encourage[d] resident to notify writer or staff for any other changes. Resident verbalized understanding."	{A 025}		

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{A 025}	Continued From page 22	{A 025}		

at 9:23 AM - "Late Entry for at 9 AM. Writer down hall to resident's room to reevaluate resident. Increased and slurred speech noted at the time. noted 911 [ ] called for transport to ER for evaluation.
at 2:39 PM - "Writer spoke with resident's daughter via phone. Daughter reports resident is being admitted to [name of hospital] with potential ."
at 2:46 PM. "No emergency contact information noted in resident's chart. Writer updated daughter number at this time."
at 10:22 AM - "Daughter called stating discharging her mother not doing well and will not be returning. Became irate and yelling alleging mother decline since she was here. Then hung up on me."

The resident's record did not contain any documentation that the family and the health care provider were notified regarding the hospital admission. The only documentation is when a family member contacted the facility on .

On at 12:45 PM, resident #12's daughter said that her mother was admitted to the hospital due to a in , she said she was not aware that her mother was admitted until the hospital contacted her. She said her mother was internally from the and was not doing well at the time of the hospital admission and she was upset that no one from the facility had called to inform her. She said she did call the facility and was upset because no one had informed her of what had occurred.

On at 3 PM, the Marketing Director who was in charge of the facility confirmed there

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{A 025}	Continued From page 23 was no documentation that the family and health care provider was contacted regarding the hospital admissions. 10. On [redacted] at 6 AM, staff G said resident #32 was sent to the hospital because he had a high [redacted] level. Review of hospital discharge paper worked revealed he was discharged from the hospital on [redacted]. On [redacted] at approximately 2 PM, the Marketing Director said there was no documentation in the facility's electronic records that noted why the resident was sent out, and that the family and health care provider was contacted. 11. On [redacted] at 9:30 AM, staff D stated that resident #3 [redacted] from his shower chair after being left in the shower sometime in [redacted], was sent to the hospital, and was now at a skilled nursing rehabilitation center. A facility report, dated [redacted] at 1:20 AM, written by staff G read, "[Name of the resident] found in the bathroom; called hospital then they took him to [name of the hospital]." Photographic evidence was obtained. On [redacted], an investigation was launched by the [redacted], neglect, and [redacted] agency and conducted at 2:24 AM as high priority, immediately confirming that staff M left resident #3 sitting on the shower chair, shut the water off and gathered his clothing. Photographic evidence was obtained. Resident #3's record revealed an admission date of [redacted]. The AHCA Form 1823 Health Assessment, dated [redacted], listed medical	{A 025}		

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{A 025}	Continued From page 24 history of [redacted], and Protein-Calorie [redacted]. He required assistance with Activities of Daily Living (ADLs) ambulation, bathing, [redacted], toileting, and transferring, and assistance with self-administration of medications. Photographic evidence was obtained. On [redacted] at 1 PM, resident #9, roommate of resident #3, stated that he observed an unknown staff giving resident #3 a shower at around 9 PM. Resident #9 stated that he woke up to resident #3 yelling for help about 12 AM or 1 AM. Resident #9 called 911 for help. On [redacted] at 3:02 PM, resident #9 confirmed that he was the one who called 911 for resident #3 when he [redacted] in the shower on [redacted]. On [redacted] at 3:05 PM, observation in resident #3 and resident #9's bathroom found that there was no emergency call bell to pull to alert staff for assistance. On [redacted] at 3:10 PM, staff G stated that she worked upstairs in the Memory Care unit on second shift [redacted] PM and worked a double third shift from 11 PM-7 AM downstairs in the 400 wing of Assisted Living residents on the day of this incident. Staff G confirmed that she wrote a quick report on [redacted] at 1:20 AM, after she learned and seen resident #3 on the stretcher being carried out to the hospital by the paramedics while she was assisting another resident a few rooms down. Staff G stated that at that time, resident #3 could not speak well and was incoherent. Staff G statetd staff M put him in the shower earlier and left him. This incident was not documented in the facility	{A 025}		

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{A 025}	Continued From page 25 notes, and no evidence provided that resident #3's healthcare provider and family were notified. The facility did not electronically submit a report to the Agency for Health Care Administration (AHCA) within 1 business day and 15 calendar days as required. Review of resident #3's hospital record revealed a date of service on [redacted] at 1:27 AM. It reflected that resident #3 was admitted for a injury after he rolled onto his left ankle and [redacted] in the shower 6 hours ago. The record reflected that resident #3's roommate attempted to call out for help multiple times while he laid on the floor for 6 hours, and was unable to obtain help from a staff member because there was only 1 caregiver working on that unit in the facility. 12. Resident #7's record revealed that on [redacted], a written grievance was submitted to the previous administrator by the family member because she was not notified that resident #7 had COVID 19 until [redacted], when she was informed by the hospital that the resident was transported to the hospital for fainting. On [redacted] at 11:55 AM, the family member wanted to know why the facility did not notify her of resident #7's change in condition. The last AHCA Form 1823 Health Assessment, dated [redacted], documented that resident #7 has a medical history of [redacted]'s [redacted], [redacted], with [redacted] and [redacted]. She was a [redacted] risk, needing supervision with [redacted] and assistance with bathing. She requires assistance with self-administration of medication. Photographic evidence was obtained.	{A 025}		

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(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 025}	Continued From page 26 There were no written facility notes about the grievance seen in the record, and no documentation of the written grievance response. 13. Resident #8's health assessment, dated , listed medical conditions of , Type 2 on oral medication, Defibrillator, and independent in all ADLs. The resident required assistance with self-administration of medications. Photographic evidence was obtained. On at 11:10 AM, resident #8 was very upset stating that staff K almost tried to kill him by trying to assist giving him triple the amount of medications at the same time the morning of . Resident #8 stated that he stopped staff K and only took the one dose prescribed because he was aware of his medications are and how he should take them. Resident #8's MORs for , and , were reviewed. There was an error on the MORs for medications listed twice and signed off twice as given as follows: , 300 mg. two capsules by every 8 hours at 7 AM, 2 PM and 10 PM, and , 300 mg. two capsules by every 8 hours at 6 AM, 2 PM and 10 PM. , 2% , three times daily at 7 AM, 2 PM and 10 PM, and , 2% , three times daily at 6 AM, 2 PM and 10 PM. , 25 mg. tablet by {12.5 mg.} daily at 7 AM, and , 25 mg. 1 whole tablet by once daily at 7 AM. Photographic evidence was obtained.	{A 025}		

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	AL11953542	A. BUILDING: _____ B. WING _____	R 09/24/2021

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{A 025}	Continued From page 27 There were no physician orders found in resident #8's record, and no facility notes for medication clarification found. On . . . . . at 9:52 AM, the Resident Care Coordinator was asked for the physician orders of the three medications found on . . , ... MORs duplicated and for any facility documentation. On . . . . . at 11:25 AM, the Resident Care Coordinator confirmed that she could not locate any physician orders and additional documentation for resident #8. On at 12:30 PM, the Interim Administrator confirmed that there were no orders found or no additional documentation could be found. There was no written documented evidence of this incident maintained in the facility notes, and no evidence provided that resident #3's healthcare provider and family were notified. In addition, the facility did not electronically submit a report to AHCA within 1 business day and 15 calendar days as required. 14. Resident #15's record revealed that on , a verbal grievance was submitted to the Interim Administrator by a family member stating that communication stopped on from the facility after she was notified via text message that resident #15 was positive for COVID 19 on . . . . . . On . . . . . at 12:53 PM, the family member stated that she continuously had to call the facility on . . . . . to follow-up with her resident #15's health change, and no one ever answered the facility telephone, and did not return a call . . . after leaving a voicemail message. The family member stated she had visited resident #15 on at 9 AM, and had to wait outside the	{A 025}		

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{A 025}	Continued From page 28	{A 025}		

gates for 30 minutes to enter. After the family member entered the facility, she asked staff K why it took so long to answer the gate and let me in. Staff K stated that the facility was short staffed. The daughter then found resident #15 near the outside front patio in soiled clothing. Daughter took her mother (#15) to her room to change her and saw no sheets on a soiled mattress on both sides. The family member stated that the facility was not taking care of resident #15 with dignity, and she was very upset about it. The family member ended up moving resident #15 out of this facility on .

Resident #15's last health assessment, dated , listed a medical history of , , and . She need assistance with self-administration of medications and was independent with all ADLs. Photographic evidence was obtained.

There were no written facility notes found in the record, and no documentation of the written grievance response.

15. Resident #31's last health assessment, dated , listed a medical history of and . He was a risk for frequent . He ambulates with wheelchair, and needs assistance with self-administration of medications. There was written documentation from his healthcare provider that resident #31 was not able to live independently on his own. Photographic evidence was obtained.

An AHCA report, dated , documented that at 4:49 PM, resident #31 had an altercation in the dining room with resident #36 because resident #31 was playing his music on his

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{A 025}	Continued From page 29 cellphone. Resident #36 grabbed resident #31's cellphone from him. There were no injuries but local law enforcement was called to the facility. No was made for either resident. On at 10:50 AM, resident #31 stated resident #36 took his cellphone in the dining room because he was playing his music on it. They both yelled at each other and the police was called. No one was hurt and no one was . It was settled after the police came and gave him the phone. There were no written facility notes documented in the record, and no notes that the legal representative and healthcare provider were notified. On at 5:45 PM, the Interim Administrator confirmed all the findings. 16. On at 11:05 AM, resident #2 stated she had just returned from a hospital stay. She stated she has had a few in the facility. Her current health assessment, dated , included diagnoses of myelodysplastic , , , and . She required assistance with ambulation and transferring. There were no observation notes regarding , hospitalization, or care for resident #2 found in the record. There was no record of notification of the resident's healthcare provider and responsible parties found. On at 12:10 PM, the resident care coordinator stated she did not have any notes or additional documentation for resident #2. 17. On at 11:25 AM, resident #6 stated the facility did not reorder his medications in time,	{A 025}		

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{A 025}	Continued From page 30 especially which is taken for . He stated "they say they are out of my medicine one day, the next day they have it, and the next day it's gone again. I don't understand. I need my medicine." Resident #6's health assessment, dated , and included diagnoses of , obstruction ( ) and , . He was noted to have an unsteady gait and was at risk for . He required assistance with ambulation and bathing. The MOR for and revealed was documented as unavailable on for the 7 AM and 7 PM doses, for the 7 AM dose, and for the 7 AM and 7 PM doses. In , was documented as "awaiting pharmacy" for both doses on and but was noted to have been given on . Photographic evidence was obtained. On at 1:10 PM, the resident care coordination stated she did not have an explanation why the medication was not always available for resident #6. 18. On at 11:15 AM, resident #24 stated he had been living in the facility for 6 years. He stated recently he had been having trouble receiving his medications consistently, specifically , a relaxant, and , an medication. He stated he only takes when he needs it, but sometimes they say they don't have it and he is not given a reason why. Resident #24's current health assessment, dated , included diagnoses of , and . Review of the MOR for and revealed , 1 mg.	{A 025}		

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{A 025}	Continued From page 31 twice daily. [illegible] was documented as "not available" on [illegible] and [illegible] for the 7 AM and 7 PM doses, and "awaiting pharmacy" on [illegible] and [illegible] for both doses. [illegible] 750 mg, every 8 hours as needed for [illegible] was noted to be given 12 times in [illegible] and 3 times in [illegible]. There were no notes on the MOR that the medication was ever not available. Photographic evidence was obtained. On [illegible] at 1:30 PM, the resident care coordination stated she did not have an explanation why the medication was not always available for resident #24. 19. On [illegible] at 11:30 AM, resident #30 was in a recliner. She had several [illegible] and bandages on her [illegible] and arms. She stated she slipped when trying to get out of bed and into her wheelchair on [illegible] and [illegible], causing her wheelchair to [illegible] on top of her. She was sent to the ER and was treated and released. Review of the record for resident #30 revealed an admission date of [illegible]. There were 2 health assessments in her record. Bothr assessments were not signed and dated by the healthcare provider. One health assessment had a [illegible] fax date on the top border from the hospital and listed diagnoses including [illegible], [illegible], and Generalized [illegible]. She required assistance with ADLs. There were no observation notes regarding [illegible], hospitalization, and care for resident #30 found in the record. There was no record of notification of the resident's healthcare provider and responsible parties found. On [illegible] at 12:10 PM, the resident care	{A 025}		

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{A 025}	Continued From page 32 coordinator stated she did not have any notes or additional documentation for resident #30. She stated she was not aware of the requirement for documentation and for notification of the physician and responsible parties when the resident experienced any changes in status. Class I	{A 025}		
{A 152} SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [illegible] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate	{A 152}		

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{A 152}	Continued From page 33 keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on observations and interviews, the facility failed to provide and maintain a home-like and decent environment in which to provide a safe living environment that was free from black and brown substance on the ceiling and air conditioning vent, stains on the walls and stained and dirty carpets throughout the facility. Findings: Observation on . . . . revealed there were brown ceiling stains next to , further observations revealed there was also black speckled substances around the air conditioner vents in the 200 hallways, and the entrance of the 400 hallway and the air conditioner vents throughout the 400 hallways. There were carpet stains throughout the entire facility and in resident's rooms and the carpet throughout the facility that looked dirty and had an odor. On at 6:15 a.m. splattered food particles were seen on the wall and base board under the	{A 152}		

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{A 152}	Continued From page 34 window of the memory care nurse's station. On .. .... at 3:15 p.m. the splattered food was still present. On at 1:35 p.m. the splattered food was still present. In addition, all of the other physical plant concerns were shown to the maintenance director, who confirmed they existed. He said the air conditioner leaked into the hallway ceiling approximately two weeks ago. He said the leak was repaired and the ceiling needed to be repaired but he was the only maintenance staff. He said carpet companies looked at replacing the carpet and gave proposals, but the facility was waiting on the money from the owners. Class III	{A 152}		