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
	AL11910963	A. BUILDING: _____ B. WING _____	10/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAZEL CYPEN TOWER	5066 NORTHEAST 2ND AVENUE MIAMI, FL 33137

(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 was conducted at Hazel Cypen Tower from . . . . . through . . . . Deficiencies were identified at the time of the survey.	A 000		
A 010 SS=G	429.26(.) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (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

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A 010	Continued From page 1 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.	A 010		

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A 010	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an 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.	A 010		

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A 010	Continued From page 3 (c) A , ill resident who no longer meets the criteria for continued residency may continue 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.	A 010		

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A 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to discharge one out of twenty- two sampled residents (Resident#1) who was admitted to the facility with a [illegible] that failed to improve within 30 days and progressed to an [illegible]. Findings Included: On at 9:47 am, observed no one living in bedroom#307, the room was empty. In an interview on at 9:45 am with Staff B, she stated Resident#1 was in the hospital due to hypoxemia (Low saturated [illegible] levels). A review of Resident#1's health assessment dated showed the resident had a medical history and diagnosis of [illegible] of right heel, region, of native [illegible], unsteadiness on [illegible], abnormalities of Gait and mobility, encounter for fitting and adjustment of [illegible] device, [illegible], and [illegible]. It also stated resident#1 required assistance with ambulation ,bathing, [illegible], self-care, toileting, and transferring. It also stated the resident had a [illegible] on the Right [illegible]. A review of Resident#1's progress notes dated on [illegible] showed Resident#1 returned [illegible] from the facility's skill nursing unit. On [illegible], Resident#1 started [illegible] care and maintenance of from a home health agency.	A 010		

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A 010	Continued From page 5 A review of Resident#1's home health interdisciplinary case conference plan dated on revealed the resident had acquired on right area and on right heel. The resident's heel was classified as as per classification guidelines. However, it was noted by the home health nurse (RN)'s assessment that the looked more like a with good sign of healing. A review of Resident#1's assessment revealed the resident started receiving services from the home health company on . It stated the resident had two (Site#1 and Site #2) that was being treated. The home health nurse was ordered to treat a on the right (Site#1) and (as per CMS guidelines) on the right heel (Site#2) however was assessed as . On , the on the right (Site#1) had progressed to a and the on the right heel (Site#2) remained a . After 30 days of receiving care from home health services on , the resident's right (Site#1) had progressed to a classified and his right heel (Site#2) was classified as . A further review of Resident#1's progress notes revealed on (14 days after documented on right) the resident was transferred to the hospital due to being with labor breathing, not for a . In an interview with Staff N (Director of Residential Care) on at 10:15 am, she stated she was unaware Resident#1 was being transferred to the facility with	A 010		

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A 010	Continued From page 6 on the resident right heel. She was informed that the resident had two , one on her right heel (Site#2) and the right area (Site#1). She stated the resident was hospitalized due his levels were too low, not because of the . In a further interview with Staff B on at 10:19 am, she stated," We have meetings every week with the home health agency to discuss each resident. They never stated the resident had a because I wouldn't have let Resident#1 come if he did". Class II	A 010		
A 025 SS=I	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	A 025		

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A 025	Continued From page 7 necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. 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. (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 observation, record review, and interview, the facility failed to provide adequate supervision as appropriate for each resident to	A 025		

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A 025	Continued From page 8 ensure awareness of the general health, safety, physical and emotional well-being for six out of 23 sampled residents (Resident # 2, #3, #6, #8, #9, and #10). Resident #3 sustained a , after falling, and Resident # 8 suffered a . Resident # 2, # 6, and # 9 all sustained throughout their body, and Resident # 10 sustained a hematoma to the after falling. Findings include: 1) A review of progress notes dated showed at 6:50 AM, Resident #2 was found lying flat on the floor near the floor of the bed. Purple discoloration was noted on the resident's mid- . When asked how she , Resident #2 stated, "I don't remember falling. I was a little ," Rescue was called, and the resident was assisted onto the bed but refused to go to the hospital. A review of Resident #2's health assessment dated showed medical diagnoses and a history of , and . The resident had precautions and needed assistance with ambulation, bathing, , toileting, and transferring. A review of Resident #2's progress notes dated showed, "Called to the resident room by the MedTech. Upon arrival, the resident was observed on the floor in a sitting position with both extended. No injury was noted. A review of progress notes dated showed, "At 5:30 AM, page received for the nurse to report Resident #2's room. Upon arrival, the resident was noted on the floor in a supine position by her bed. Upon nurse assessment,	A 025		

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A 025	Continued From page 9 resident skin was noted intact no visible injury was noted. Resident assisted off the floor by two staff." A review of Resident #2's progress notes dated showed that at 9:10 PM, staff was called to the resident's room. Upon arrival, the resident was found sitting on the floor next to her bed. When asked how she , Resident #2 stated, "I was going after my lamp. I slid to the floor, then I called for help." No injury was noted. A review of progress notes dated showed "Found [Resident #2] sitting on the floor close to her bed with walker close to the bed. The resident could verbalize what was going on, she voiced she tried to go to the bathroom, and she lost her balance. Resident assisted from the floor to a standing position by two staff. No injury noted." A review of Resident #2's progress notes dated showed that the resident complained of having left , , after falling on . When evaluated by the nurse practitioner, Resident #2 reported having left , surgery due to a she had many years ago. An , was taken of the left , , and the resident was given . A review of progress notes dated showed at 11:25 PM, Resident #2 was found in a sitting position leaning against her bed. The resident was assisted to bed by four staff. A review of Resident #2's Personal Service Plan dated showed that the resident would begin , , , as an intervention for her . There was no documentation of any new interventions after the resident first on	A 025		

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A 025	Continued From page 10 . . . . . . A review of Resident #2's progress notes showed no documentation that the resident received . . . . . . A review of the facility's prevention policies and procedures showed the 'residents who have risks identified will have personalized interventions included in their Personal Service Plan. Following a , the associates complete the Post investigation to determine if the resident's risks have changed or if any interventions need to be updated.' A review of Resident #2's record showed no documentation of Post investigations for any of the resident's . 2) A review of Resident #3's progress notes dated . . . . . showed the resident was on the floor in a sitting position in front of the dresser. Resident #3 stated I was here for a long time. Can you help me?" The resident was transferred . . . to bed. A . . . was noted on her right . A review of Resident #3's health assessment dated . . . . . showed medical diagnoses and a history of 's , , . . . , and COVID-19. The resident had precautions and needed assistance with ambulation, bathing, ... , toileting, and transferring. A review of the adverse incident report filed on . . . . . showed on . . . . . at 5:15 AM. Resident #3 was assisted to the bathroom by CNA staff. The CNA left the resident in bed. At 5:55 AM, staff heard Resident #3 call, "hello,	A 025		

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A 025	Continued From page 11 hello." Upon arrival, Resident #3 was found on her next to her bed with a bump on her forehead and a on her left . The resident complained of in her left . The resident's medical provider was contacted and ordered the resident to be transferred to the hospital. Resident #3 sustained a to the left . A review of progress notes dated showed, "At 5:55 AM, upon arrival [Resident #3] was noted on the floor on her by her bed. When asked what happened, she stated, 'I don't know, can you help me?' The resident was assisted off the floor into bed. The resident had a to the left and a hematoma to the right side of the forehead. The resident's son and hospice were notified. Hospice came to assess [Resident #3] and received an order from the physician to transfer the resident post- due to the left ." In an interview with at 2 PM, Resident #3's hospice nurse stated, "I was only aware of the resident falling on that resulted in her fracturing her left . I was not aware of the resident falling on ." A review of the facility's prevention policies and procedures showed the 'residents who have risks identified will have personalized interventions included in their Personal Service Plan. Following a , the associates complete the Post investigation to determine if the resident's risks have changed or if any interventions need to be updated.' A review of Resident #3's record showed no documentation of Post investigations for any of the resident's .	A 025		

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A 025	Continued From page 12 3) A review of Resident #6's progress notes dated [illegible] showed at 10:30 AM, "Observed resident laying on his [illegible] on the floor. The resident's walker was noted to be about 4 [illegible] away. A small [illegible] was noted to the [illegible] of the resident's right upper arm. A review of Resident #6's health assessment dated [illegible] showed medical diagnoses and a history of [illegible], and [illegible] type 2. The resident had [illegible] precautions and needed supervision with self-care, toileting, transferring, and assistance with ambulation and bathing. A review of progress notes dated [illegible] showed that at 1:15 PM, [Resident #6] was found lying supine on the sidewalk with [illegible] on his left arm. The resident sustained two [illegible] on his left arm near his [illegible]. A review of Resident #6's progress notes dated [illegible] showed, "while passing medication on the first floor, staff heard help coming from resident's room. When entering his room, the resident was found side-lying on the floor next to his bed. The resident said, 'I slipped and [illegible], hit my [illegible] pretty hard.' The resident noted with [illegible] approx. 2.5 cm long on the [illegible] of his [illegible]. 911 was called. The paramedic came and assessed the resident. Resident transferred to [hospital]." A review of Resident #6's hospital records dated [illegible] showed that the "patient is a male who presents after a mechanical [illegible] from the rolling chair. Struck [illegible] on the ground in the incident, denies loss of [illegible]. Presents	A 025		

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A 025	Continued From page 13 with . . . , ... and . . . . of the right . " A review of Resident #6's progress notes dated . . . . . showed, "At 1:30 PM arrived at bedside resident observed on the floor in supine position . . . under the bedside table upon assessment resident complained of , on right , . A call was placed to rescue around 1:40 PM. The resident transferred to [hospital]." A review of Resident #6's hospital records dated . . . . . showed, "patient presents for . from nursing home states he slipped off the edge of the bed and to the floor and was unable to stand for 4 hours. The patient was seen yesterday for a . with a negative . . computed . , , and C , with . . . . . repaired. Sudden onset, progressively worsening, mild severity, no radiating and associated symptoms." A review of Resident #6's progress notes dated . showed the resident was found sitting on the floor in front of his bed. No injuries were noted. A review of progress notes dated showed at 9:30 AM, "During rounds found [Resident #6] on the floor in front of his bathroom in supine position with a pillow underneath the . The resident stated he was coming out of the bathroom; he lost his balance and . on his left side. Assessment reveals to the left . . and left . . . ." A review of Resident #6's progress notes dated showed at 7:10 AM, the resident was found lying on the floor next to his bed. The resident had no injuries.	A 025		

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	AL11910963	A. BUILDING: _____ B. WING _____	10/11/2021

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A 025	Continued From page 14 A review of progress notes dated showed that Resident #6 was found on the floor in front of his door. When asked what happened, the resident stated, "I slipped in front of my bathroom and crawled to the front door to get help." No visible injuries were noted. A review of Resident #6's progress notes dated showed, "At 6:20 AM page received from CNA on duty to report as she enters the room after several attempts to assist the resident with care, he refused. During the last round, the resident was noted on the floor. The nurse went to assess, and upon arrival, the resident noted on the floor down between the bathroom door and hallway. was noted to arms; the resident stated, 'please help me up.' When staff attempted to assist the resident up, he screamed, 'no, no, I am hurting all over. A call was placed to Rescue for further assistance. At around 6:50 AM, Rescue arrived as they were attempting to assist the resident and try to roll resident over the resident screams 'no no' and use some other words, 'I am hurt what are you doing.' Rescue picked the resident up, sat him in the wheelchair, performed first aid to the arm, and covered it with a dry . Rescue asked the resident if he wanted to go to the hospital, resident said no. Then rescue assisted resident to bed did not transport the resident to the hospital." A review of second progress notes dated showed, "At 10:30 AM call from nurse aide on duty reporting [Resident #6] found on the floor. Upon arriving, the resident was observed on the floor on his left side , against the wall, complaining of , , screaming with foul language, and tried to assist. A call was placed to	A 025		

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A 025	Continued From page 15 rescue 911. The resident refused hospital transfer stating, 'I'm okay." A review of Resident #6's Personal Service Plan dated showed no documentation of any interventions after the resident first on . A review of the facility's prevention policies and procedures showed the 'residents who have risks identified will have personalized interventions included in their Personal Service Plan. Following a , the associates complete the Post investigation to determine if the resident's risks have changed or if any interventions need to be updated.' A review of Resident #6's record showed no documentation of Post investigations for any of the resident's . On at 12:17 PM, when asked what preventive measures were in place for Resident #6, the Director of Resident Care stated, "We completed constant rounding, and we also encouraged him to call for assistance." A review of Resident #6's progress notes showed no documentation of physician recommendations to prevent the reoccurrence of . On at 12:20 PM, when asked whether the facility contacted Resident #6's medical provider about the resident's , the Director of Resident Care stated, "He didn't have a doctor. [Resident #6] 's son would say he would take him." 4) A review of the adverse incident filed on showed that around 9:55 AM,	A 025		

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A 025	Continued From page 16 Resident #8 was found on the floor lying on her right side by the housekeeper. The Director of Resident Care was called to the resident's room, and when asked what happened, the resident stated she was making her bed and slipped. The paramedics were called at 10 AM, and when assessed, Resident #8 complained of , in her right . The resident was transferred to the hospital, where she was diagnosed with a displaced of the surgical , A review of Resident #8's progress notes dated showed at 10 AM, the resident was found lying in front of the bedroom door. The resident stated, "I was going to make my bed, slipped and ." Resident #8 complained of , in the right , and right . The resident was transferred to the hospital. At 3:40 PM, the resident returned to the facility with a sling to her right arm. A review of Resident #8's health assessment dated showed medical diagnoses and a history of , and . The resident had precautions and needed assistance with ambulation, bathing, , toileting, and transferring. A review of progress notes dated showed at 11:44 AM, "Call placed by CNA for a nurse to report to [Resident #8] 's room. A resident was observed on the floor in the hallway by the bathroom in a sitting position. The resident denied , and discomfort and was able to move lower extremities without complaint. The resident stated, 'I was going to use the bathroom.' The resident was reinstructed to the necessity to call for assistance as needed and to keep the sling in place."	A 025		

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A 025	Continued From page 17 A review of second progress notes dated showed at 7:30 PM, Resident #8 was found on the floor lying on her left side with the sling off of her arm. When asked how she , the resident stated, "I was going to get my phone; I slipped and ." A review of Resident #8's progress notes dated showed at 11 AM, the Director of Resident Care was called to the resident's room, and upon arrival, Resident #8 was observed lying on her on the floor next to her bed. The resident stated, "I was trying to pull my cell phone in the socket to get charged, lost my balance, and hit my right ." No injuries were noted. A review of progress notes dated showed at 4:05 PM, "Staff reported that resident was in the front lobby and verbalized that she slipped in the bathroom in the apartment. Upon arrival to the lobby, the resident was noted sitting with no shoes on and conversing with others. The resident expressed that she was wearing her slippers and took them off after the unwitnessed incident. No visible injuries noted at this time." A review of Resident #8's progress notes dated showed at 11:40 AM, the resident was observed sitting on the floor of the closet with her walker next to her. When interviewed, Resident #8 stated, "I left my walker to go inside the closet, and I lost my balance and ." Staff noted that there were no apparent injuries. A review of Resident #8's Personal Service showed no documentation of any interventions after the resident first on . A review of the facility's prevention policies	A 025		

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A 025	Continued From page 18 and procedures showed the 'residents who have risks identified will have personalized interventions included in their Personal Service Plan. Following a , the associates complete the Post investigation to determine if the resident's risks have changed or if any interventions need to be updated.' A review of Resident #8's record showed no documentation of Post investigations for any of the resident's . 5) A review of the adverse incident filed on , the Front desk contacted nursing staff at 8:30 PM to inform them that Resident #9 was on the floor. Upon arrival, Resident #9 was found in a sitting position with her daughter applying pressure to a on the left side of her forehead. Rescue was called, and the resident was transported to the hospital. A review of Resident #9's progress notes dated showed, "At 8 PM, a nurse was called by the front desk to come downstairs. Upon arrival, resident sitting on floor , with daughter applying pressure to injury while holding her dog with her other . Her daughter stated as they were walking through the door, mother tripped on the carpet and . She hit her against a silver metal stand and left her on the floor. The nurse noted a on the left side of her . 911 called and the resident transferred to the [hospital]." A review of Resident #9's hospital records dated showed, "patient is a female brought in by after ground-level mechanical resulting in a to the left forehead. The patient has also complained of left , repaired with seven ; patient	A 025		

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A 025	Continued From page 19 tolerated procedure well." A review of Resident #9's health assessment dated showed medical diagnoses and a history of hypertensive , Atherosclerotic , of the left , , and . The resident had precautions and was independent with , grooming, toileting, transferring, and needed supervision with bathing, eating, and assistance with ambulation. A review of Resident #9's progress notes dated showed at 6:10 PM, "Med Tech reported during med pass resident reported that she while taking and picked herself up from the floor. The right ankle is hurting, and Med Tech noted right ankle swelled a little. The resident refused to be transferred to hospital." A review of progress notes dated showed at 8:01 PM; staff found Resident #9 seated on the floor in front of the elevator. A review of second progress notes dated showed at 9:35 PM, "Call received from concierge reported [Resident #9] is on the floor close to the elevator. Upon arrival, the nurse noted the resident in sitting position on the floor near the elevator with walker located on her ." No injuries were noted. A review of the facility's prevention policies and procedures showed the 'residents who have risks identified will have personalized interventions included in their Personal Service Plan. Following a , the associates complete the Post investigation to determine if the resident's risks have changed or if any	A 025		

Agency for Health Care Administration

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A 025	Continued From page 20 interventions need to be updated.' A review of Resident #9's record showed no documentation of any Post investigations completed after any resident's 6) A review of Resident #10's progress notes dated showed that the resident the night before. Resident #10 complained of and was unable to bear on his right side. When asked how he , Resident #10 stated, "I last night. I just collapsed at the bedside coming from the bathroom. My wife had to help me get to bed." A was noted on the right arm, and the left lower . A review of Resident #10's health assessment dated showed medical diagnoses and a history of , , , , and . The resident had no precautions and needed assistance with ambulation, bathing, , toileting, and transferring. A review of the adverse incident report filed on showed that staff found 8 AM Resident #10 lying on the bathroom floor. The resident sustained a to his right , a to his left , and a lump to the of his . The resident stated he was going to the bathroom when he lost his balance and . The paramedics were contacted, and the resident was transferred to the hospital. A review of Resident #10's progress notes dated showed, "Director of Resident Care received a call from the nurse to come to the room. Entered room and noted nurse next to the resident. The resident was lying on his with	A 025		

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A 025	Continued From page 21 a [illegible] to the right [illegible], a [illegible] to the [illegible], and a lump in the [illegible] of his [illegible]. The nurse applied pressure to the [illegible] on the [illegible] to stop [illegible]. The resident stated he rang his call light and proceeded to go to the bathroom when he attempted to turn to sit on the commode, lost his balance, and [illegible]. A call was placed to the resident's son to inform him. Resident transferred to [hospital]." A review of Resident #10's hospital records dated [illegible] showed, "patient is a male with a history of [illegible] and [illegible] brought in by rescue after an unwitnessed [illegible]. The patient states he was going to the bathroom and 'ended up on the floor' but cannot describe why or how he [illegible]. Admits to [illegible] strike but denies loss of [illegible]. Has a left occipital [illegible], hematoma and [illegible] of the right [illegible]. Symptoms severe in intensity, non-radiating, no aggravating or alleviating factors." A review of Resident #10's records showed no documentation of an updated health assessment after the resident's [illegible]. A review of the facility's [illegible] prevention policies and procedures showed the 'residents who have [illegible] risks identified will have personalized interventions included in their Personal Service Plan. Following a [illegible], the associates complete the Post [illegible] investigation to determine if the resident's [illegible] risks have changed or if any interventions need to be updated.' A review of Resident #10's record showed no documentation of his interventions to prevent his [illegible]. There was also no documentation of any Post [illegible] investigations completed after any of the resident's [illegible].	A 025		

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A 025	Continued From page 22 A review of the facility's prevention policies and procedures showed 'a assessment is completed for each resident upon move-in, upon change of condition and every six months thereafter.' Record review of the residents who have at the facility showed no documentation of risk tool completed at admission nor after any of the resident . Class II	A 025		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and,	A 054		

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A 054	Continued From page 23 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an accurate daily medication observation record for one out of 22 sampled residents (Resident #11). Findings included: Review of the Medication Observation Record (MOR) for Resident #11 revealed an order for [illegible], 81 MG tablet to be given by [illegible] twice daily, an order for [illegible] SOD 100 MG capsule to be given by [illegible] twice daily, an order for Ferosul 325 MG tablet to be given by [illegible] twice daily, and an order for [illegible] 12.5 MG tablet to be given by [illegible] once daily. Further review of the MOR for Resident #11 revealed [illegible], 81 mg tablet, [illegible] SOD 100 MG capsule, Ferosul 325 MG tablet, and [illegible] 12.5 MG tablet were not signed as being given on [illegible] for the 9 AM scheduled dose. During an interview on [illegible] at 12:45 PM, Staff C stated "Resident #11 wakes up late everyday. This day she came down to the nurses office and I saw a resident walking near the pool, so I got distracted with going to help that resident. I forgot to sign off her medications as given. I'm	A 054		

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A 054	Continued From page 24 sorry." Class III	A 054		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. [illegible], 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance [illegible], 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [illegible], or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823	A 162		

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A 162	Continued From page 25 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their [illegible] recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an [illegible] recipient, a copy of the Department of Children and Families form Alternate Care Certification for [illegible] ([illegible]), CF-ES 1006, [illegible], which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required	A 162		

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A 162	Continued From page 26 documentation from the Department of Children and Families. (m) Documentation of the , , ... of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's . . . . . , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility.	A 162		

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	AL11910963	A. BUILDING: _____ B. WING _____	10/11/2021

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A 162	Continued From page 27 (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an accurate health assessment for three out of 22 sampled residents (Resident #4, #5, and #7). Findings included: Review of Resident #4's health assessment (AHCA Form 1823) completed on . . . . revealed Resident #4's health assessment was missing a physician number and address. Review of Resident #5's health assessment (AHCA Form 1823) completed on revealed she required assistance with self administration of medication. Review of Resident #7's health assessment (AHCA Form 1823) completed on . . . . revealed he required assistance with self administration of medication. During an interview on . . . . at 1 PM, The Director of Resident Care (Staff B) stated "Resident #5 and #7 receive medication administration from a nurse at the facility. The Director of Resident Care further acknowledged the errors and stated "I will get it fixed." Class III	A 162		

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A 165	Continued From page 28	A 165		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse	A 165		

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A 165	Continued From page 29 incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a	A 165		

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A 165	Continued From page 30 licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to file an adverse incident report with the Agency for Health Care Administration within one business day and fifteen days for one out of 23 sampled residents (Resident #6). Findings include: A review of Resident #6's progress notes dated . . . . . showed, "while passing medication on the first floor, staff heard help coming from resident's room. When entering his room, the resident was found side-lying on the floor next to his bed. The resident said, 'I slipped and . . , hit my pretty hard.' The resident noted with . . . . . approx. 2.5 cm long on the . . . of his . 911 was called. The paramedic came and assessed the resident. Resident transferred to [hospital]." A review of Resident #6's hospital records dated . . . . . showed that the "patient is a male who presents after a mechanical from the rolling chair. Struck . . on the ground in the incident, denies loss of . . . . . Presents	A 165		

Agency for Health Care Administration

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A 165	Continued From page 31 with . . . , ... and . . . of the right . " A review of the agency's adverse incident database showed no incident reports were filed for Resident #6's injury. During an interview on at 12:25 PM, when asked when the facility reports incidents to the agency, the Director of Resident Care stated, "I report if they . with injury. [Resident #6] came from the hospital the same day." Class III	A 165		