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
	AL11968053	A. BUILDING: _____ B. WING _____	12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN HOUSE SENIOR LIVING #1	3991 CR 210 WEST ST JOHNS, FL 32259

(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 relicensure survey and complaint survey (complaint 2021009465) was conducted at Golden House Senior Living #1 on . Deficient practice was identified at the time of the survey.	A 000		
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	A 165		

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A 165	Continued From page 1 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 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	A 165		

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A 165	Continued From page 2 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 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 observation,record review, and staff interview, the facility failed to report an adverse incident to the Agency for Health Care Administration (AHCA) when one resident seven sampled residents while using the toilet without the assistance of staff (Resident #3). The findings include: On , an observation was made of Resident #3 getting assistance from the Administrator to walk from a chair near the medication cart to the living room. The Administrator held her arm and walked next to her. The resident appeared unsteady and shuffled her . On at 2:25 pm, she was walking with the assistance of Employee A, Caregiver, who was holding Resident #3's arm as she led her to the living room to sit down.	A 165		

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A 165	Continued From page 3 Review of Resident #3's record revealed an incident form that indicated she in the bathroom on at 3:20 pm. The description of the incident read, "Resident was on the toilet, after finished she tried pull the pull ups turn and . No injury noted." Steps taken to prevent recurrence included calling rescue, and ambulance came to pick her up. The form was signed and dated by Caregiver B on at 3:30 pm. A Resident Communication Form was also filled out which detailed that Resident #3 on , and was sent to the hospital. Photographic evidence obtained. Review of the Health Assessment (Form 1823) dated revealed Resident #3 needed assistance with toileting. The assessor documented she needed assistance with ambulation, and needed precautions. A second 1823 dated also indicated she needed assistance for toileting. Photographic evidence obtained. Review of the Hospice Provider Nursing Worksheet dated revealed Resident #3 was required for ambulation by two people. She was totally dependant on others for toileting, , and bathing. Photographic evidence obtained. The plan of care created by Hospice stated Resident #3 was a risk due to her progression, dated . Photographic evidence obtained. During an interview with the Administrator on at 10:50 am, she stated no adverse incidents had been filed with AHCA. She had not had any incidents to report.	A 165		

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A 165	Continued From page 4 During a second interview with the Administrator on . . . . . at 3:00 pm she stated that Resident #3 was in the bathroom by herself when she . . She confirmed the 1823 dated . . indicated the resident required assistance for toileting. She stated the 1823 wasn't accurate because, "she can go by herself. She would be in there and . . . . before I even knew she left the room." The Administrator stated that she had other residents to look after and could not be in the restroom with Resident #3 and leave the other residents unattended. When asked if she filed an adverse incident report with AHCA, she stated she did not think she needed to. The criteria for an adverse incident report was reviewed and she confirmed that because the resident was assessed as requiring assistance with toileting when she was admitted, the staff should have exercised control over the situation when the resident . She was alone in the bathroom when she . , and she should not have been. Class III	A 165		