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 12/07/2021

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 second revisit to complaint investigation # 2021007444 was conducted at The Palms of Longwood Assisted Living Facility on and . Deficiencies were identified at the time of survey.	{A 000}		
{A 025} SS=D	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	{A 025}		

AHCA Form 3020-0001

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

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953542	A. BUILDING: _____ B. WING _____	R 12/07/2021

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 025}	Continued From page 1 resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on observations, record reviews and interviews, the facility failed to follow a health care provider's order for 3 of 12 sampled residents (#24, #29 & #37) and failed to document in the resident's record when 1 of 12 sampled residents experienced a significant change when development of a , ... occurred (#37). Findings: 1. Review of resident #37's record revealed the resident was admitted to the facility on ,	{A 025}		

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 12/07/2021

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 025}	Continued From page 2 her diagnoses included 's , acute , , , , , and . A hospice note, dated , indicated facility staff voiced concerns regarding the resident's heels. The note indicated the resident had dark circular eschar on the left heel and a very small area of dark eschar on the right heel. A health care provider's note, dated , indicated both heels had tissue, and both were . A health care provider's order, dated , instructed to "paint area on left heel with daily. Apply skin prep or similar barrier wipe to heels. Make sure is only applied to base and not surrounding skin." Continued review of the resident's record revealed it did not contain facility documentation to indicate when the resident developed the . An opportunity was given to the DON to provide this information however, she was unable to. On at 10:15 a.m. the DON identified resident #37 as having a , on her heel. The DON said the treatment was application of and said the unlicensed staff were responsible for applying it. On at 11:35 a.m. unlicensed staff R said she had applied to resident #37's heel that morning and said it was ordered to be applied every day. On at 11:37 a.m. unlicensed staff P said	{A 025}		

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 12/07/2021

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 025}	Continued From page 3 when she assisted resident #37 with medications, she too applied to the resident's heel and said it was ordered to be applied every day. Observations made on at 8:04 a.m. revealed resident #37 was laying on her in her bed. Both of her heels were floated on pillows. Unlicensed staff R was seen washing her then donning gloves. Staff R opened a package of sterile gauze then poured solution onto the gauze. While staff P held the resident's up, staff R used the gauze to apply the to the left heel , including the intact skin that surrounded the . She then folded the same gauze, poured more on it, then used it to apply to the resident's right heel, which did not have a but rather had only intact skin. In addition, although there were skin prep wipes on top of the resident's dresser, staff R never applied skin prep to the resident's heels, as was prescribed. On at 2:20 p.m., the findings were discussed with staff R, including the fact that she was not licensed to apply the to the and that she applied it to the skin surrounding the , despite the order not to. Staff R only nodded her . 2. Review of resident #29's record revealed an 1823, dated , that indicated the resident's diagnoses included type 2 and the resident required assistance with self-administration of medications. The record contained a health care provider's order, dated , to check resident's (BG) three times a day before meals and to inform the provider for any random	{A 025}		

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 12/07/2021

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 025}	Continued From page 4 levels >300 or <50. Review of the resident's and MORs revealed the following BG results: - 301 - 362 - 336 - 355 - 349 - 367 & 313 - 359 & 306 - 380 - 319 & 306 - 325 & 369 - 378 - 356 - 310 - 380 - 368 Neither the MORs nor the resident's record contained documentation to indicate the facility informed the health care provider each time the BG result was >300. On at 3:50 p.m., the findings were discussed with the DON, who confirmed them. An opportunity was given for her to provide additional documentation. She returned, said she was unable to locate additional documentation and said she tried to contact the provider to ask whether he was informed of the results but she had been unable to speak with him. Observations made on at 11:07 a.m. revealed staff D assisted resident #29 with checking the resident's BG. The result was 368.	{A 025}		

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 12/07/2021

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 025}	Continued From page 5 On ... ... at 1:50 p.m., when asked if he informed either the health care provider or DON when resident #29's BG was 368, he said no because no one told him that he had to. He pointed out that the resident's MOR did not contain instructions to do so either. On at 2:10 p.m., the DON said the pharmacy updated the facility's MORs, said she was aware of issues associated with that process and said she was trying to figure it out. 3. Review of the record for resident #24 revealed an order dated ... for ... 0.1mg, 1 tablet twice a day for 30 days. Also present in the record was an order dated ... from his health care provider which read "monitor , ... daily in the AM for 1 month. Started on ... 0/1mg, PO, ." Review of the medication observation record (MOR) for resident #24 did not reveal any documentation of the daily , ... readings. (Photographic evidence obtained) On at 2:35PM, the nursing director stated she was unaware of the order for daily , monitoring, and confirmed she was unable to find any documentation that the , were being monitored. Class III	{A 025}		