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
	AL11964204	A. BUILDING: _____ B. WING _____	12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD PLACE	2680 CROTON ROAD MELBOURNE, FL 32935

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint survey #2021016181 was conducted on [redacted] at Greenwood Place, Melbourne. A deficiency was found at the time of the visit.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 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.	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
	AL11964204	A. BUILDING: _____ B. WING _____	12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD PLACE	2680 CROTON ROAD MELBOURNE, FL 32935

(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 (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interviews the facility failed to provide care and services appropriate to meet the needs of 1 of 4 residents (#1) who had numerous and sustained injuries; 2) did not follow the facility's policy and procedures for residents who are risks. Findings: In a review on of resident #1's health assessment dated , revealed a diagnosis of , repeated , unspecified , transient . It also confirmed assisted daily living (ADLs) of	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964204	A. BUILDING: _____ B. WING _____	12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD PLACE	2680 CROTON ROAD MELBOURNE, FL 32935

(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 supervision for ambulation, bathing, ..., self-care, toileting, and transferring. In a review of facility notes for resident#1, it confirmed several unwitnessed . . . as follows: . . . . . 5:50 Med tech observed resident on floor on the right side with bended, . was under sink, ... noted in hair and . . . . Resident stated to emergency medical technician (EMT) that she was coming from the bathroom and lost balance and on her of her , right collar, and . . . hurts. Resident sent out to hospital. 9:52 resident returned from hospital has bandage on . . . from . . . . . . No stitches required. New order for skilled nursing Resident seen by home care nurse. 6:04 Resident Aide found resident on floor. Resident hit bottom . . . on wall but refused to go to emergency room. 23:24 Resident was heard by staff yelling for help. Staff entered the room and found the resident in bathroom, and she hit her in the shower. Resident stated she had , in the , and area. Shower chair on its side in the shower next to her. Vitals were taken. 911 was called, resident agreed to be transported. . . . . . 4:17 Resident trying to ambulate from toilet without her walker from the toilet. Resident lost balance, she was not wearing her nonskid socks or shoes. Vital signs taken. Resident assessed with no injuries.	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964204	A. BUILDING: _____ B. WING _____	12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD PLACE	2680 CROTON ROAD MELBOURNE, FL 32935

(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 00:24 Resident was observed on floor by caregiver laying on left side. Resident stated that she hit her . 911 was called and she was sent to the hospital. 4:10 am Resident arrived from hospital. 3:25 Resident was calling out from bathroom. caregiver checked on resident she was on her left side and from her . She was alert and able to talk. noted to left , . 911 was called and resident was transported to hospital. Resident received stitches. 9:13 Resident was found on floor on both with out in front of her. She was not wearing her nonslip socks or shoes. Vitals were taken No injuries noted. Resident had a overnight as reported by staff. Resident was observed on the floor by her bed on her and she asked to be sent to the hospital because her was hurting. / Returned from hospital. 7:02 Resident reported to staff that she and hit her and it was hurting. Resident was sent out to the hospital. In a review on of the facility policy for risk residents, it states moderate to high-risk residents are to put on the star program, weekly meetings, review mobility risk checklist, refer to interventions recommendations, and involve 3rd parties. The facility star program for risk residents state that the administrator and or wellness director will involve the primary physician, the family and responsible parties to discuss and	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964204	A. BUILDING: _____ B. WING _____	12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD PLACE	2680 CROTON ROAD MELBOURNE, FL 32935

(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 implement proper interventions for the resident to prevent . In an interview with Staff A on at 10:30am She stated she is not aware of any interventions for residents that are risks. In an interview with Staff B on at 10:40am she confirmed the residents are checked every 2 hours but is not aware of any other interventions for . risk residents. In an interview on at 12:50am with the family member and Power of Attorney, she confirmed that there were no interventions put into place for resident #1. The facility did not initiate any meetings or discussions on interventions or higher level of care to prevent . In an interview with the wellness Director on at 10:15am, she confirmed the facility policy was not followed by not implementing interventions to prevent for resident#1 and not setting up a meeting to discuss interventions with the family, the primary physician or 3rd party health care staff. On at 1:00pm, the administrator confirmed the findings above. Class II	A 025		