

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/10/2022
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WICKSHIRE PORT ORANGE

**1675 DUNLAWTON AVENUE
PORT ORANGE, FL 32127**

(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 investigation (complaint number 2022003595) was conducted at Wickshire Port Orange Assisted Living Facility 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;	A 165		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 165	Continued From page 1 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 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	A 165		

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A 165	Continued From page 2 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 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 interview and record review, the facility failed to report an adverse incident related to transfer to a higher level of care within 1 business day of occurrence for one of three sampled residents (Resident #1). The findings include: A record review was conducted for Resident #1 which noted a diagnosis of _____ and _____ . Resident #1 was ordered _____ 5 milligrams (mg) twice a day for her _____. A review of her Medication Observation Record (MOR) for _____ revealed the medication was not given on _____.	A 165			

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A 165	Continued From page 3 at 8:00 a.m., at 8:00 p.m. or for either 8:00 a.m. or 8:00 p.m. The medication was reordered per Omnicare's records on,, and Resident #1's record showed she was hospitalized for a The investigation conducted by the Clinical Director, RN, noted the event was brought to her attention on (Photographic Evidence Obtained). The Health and Wellness Director (HWD) was supposed to be auditing medications that were missed on a daily basis. Nowhere in the note does it reference an adverse incident was filed. The medication carts were to be audited once a week and a report given to the Executive Director (ED). Review of a Corrective Action Form provided by the facility showed the ED received a warning for not filing the adverse incident timely. Page 2 of the form mandated she report within 24 hours of an incident. This was signed on (Photographic Evidence Obtained.) An interview was conducted with the ED on at 3:06 p.m. She reported the incident was faxed to AHCA on, around 1:00 p.m. the day of the survey (Photographic Evidence Obtained). Class III	A 165		