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
	AL11969591	A. BUILDING: _____ B. WING _____	03/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERTUS WL OPCO LLC	11120 LAKE UNDERHILL ROAD ORLANDO, FL 32825

(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 a Generator Monitoring were conducted on [redacted]. Certus WL OPCO LLC had deficiencies 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		

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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 observations, record reviews, and interviews, the facility failed to provide adequate supervision, and failed to provide care and services appropriate to meet the needs to ensure safety through proactive measures to minimize the potential for and injuries for 1 of 2 sampled residents who experienced repeated with significant injuries (#4). Findings: Resident #4's record revealed a facility admission date of . An 1823 assessment form, dated , indicated the resident had memory loss, was easily , and was independent with ambulation and transferring.	A 025		

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A 025	Continued From page 2 The resident's record revealed the following documentation: On at 10:01 p.m., the resident was observed by care staff ambulating down the hallway to her apartment when she tripped and . She was from her . Pressure was applied. She was alert and verbally responsive. She was taken to the hospital. On at 5:09 p.m., the resident returned from the hospital at approximately 3 p.m. was matted in her hair. On at 10:01 p.m. the resident was ambulating throughout the community. She was encouraged to wear non-skid shoes. On , a health care provider ordered home health skilled nursing to evaluate and treat for removal of to a . On at 11:20 p.m., the resident was found on the floor. Her were open, and she was responsive. was coming from the right side of her . She was unable to provide a description of what occurred. Emergency Medical Services ( ) was called. The resident's family did not want the resident to be sent to the hospital. On at 11:55 a.m., the resident was found holding on to her right and shaking. She was sent to the hospital. On at 6:10 p.m., the resident returned from the hospital. Review of a hospital history and physical, dated , revealed documentation that indicated the resident had , a large hematoma and on her that was	A 025		

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A 025	Continued From page 3 sutured, and a . . . . . . The hospital history and physical, dated . . . . , reflected the resident guarded her right , winced in , when it was palpated and when passive range of motion was attempted, had a displaced right . . . . , and a . . . . On at 10:09 a.m., the resident sat in a wheelchair in the Memory Care unit's common area. Staff F and G were seen transferring the resident to a sofa by lifting both of the resident's arms up slightly then placing each of their on the resident's upper, inner arms. A soft sling was seen on the resident's right arm. When asked about the transfer, staff F said the resident had an injury to her right . On at 2 p.m., the Wellness Director said she did not know why the resident had to wear the sling. She said she requested the hospital records from the resident's visit there on . . . . She said when the resident's family member visited on that morning, the family said they too did not know what was wrong with the resident's right arm and said no one from the hospital told them anything. On at 1:56 p.m., the resident's family member said she received a call from the facility on the night of telling her the resident was found on the floor. The facility called . . . but due to the resident's hospital visit following her . in . . . . . , she did not want the resident to be sent to the hospital. The family member received a call from the facility on telling her the resident was in , , so she agreed to have the resident sent to the hospital. She learned from the hospital that the	A 025		

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A 025	Continued From page 4 resident broke her right [illegible] and suffered a [illegible]. The resulting two choices were surgery or hospice services, so the family chose hospice. She said she told the Wellness Director that the resident's [illegible] was broken, and it was the Wellness Director who applied the sling that morning. On [illegible] at 2:18 p.m., the Wellness Director said the facility's [illegible] interventions for resident #4 was physical and [illegible], and non-skid shoes. The Wellness Director said staff were not trained to properly transfer the resident with the [illegible] injury and sling. On [illegible] at 2:25 p.m., the resident was seen lying in bed. Her [illegible] were closed, she was on her [illegible] with her upper body positioned slightly to her right. The sling was on her right arm. On [illegible] at 2:27 p.m., staff F said to decrease the resident's risk for [illegible], she kept the resident within her eyesight. Staff F said she did not receive training on how to safely transfer the resident with a broken right [illegible]. On [illegible] at 2:30 p.m., staff G said to decrease the resident's risk for [illegible], she kept an [illegible] on the resident, tried to grab the resident's [illegible] during ambulation, and assisted the resident to the bathroom. Staff G said she did not receive training on how to safely transfer the resident following the broken right [illegible]. Class II	A 025		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin	A 052		

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A 052	Continued From page 5 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (h) Using a to perform -level checks.	A 052		

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A 052	Continued From page 6 (i) Assisting with putting on and taking off stockings. (j) Assisting with applying and removing an but not with titrating the prescribed settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with bags. (4) Assistance with self-administration does not include: (a) Mixing, converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of	A 052		

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A 052	Continued From page 7 dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's	A 052		

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A 052	Continued From page 8 health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and	A 052		

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A 052	Continued From page 9 interview, the facility failed to ensure the unlicensed staff, who assisted 1 of 3 sampled residents with medications, followed the correct procedures (#13). Findings: Resident #13's record revealed a facility admission date of . An 1823 health assessment form, dated , indicated the resident's diagnoses included , Body , and that the resident required assistance with self-administration of medications. " with , bodies (DLB) is a progressive, degenerative of unknown . Affected patients generally present with preceding motor signs, , with visual and episodes of reduced responsiveness." (reteived emedicine.medscape.com/article/1135041). Observations made during a medication pass for resident #13 on at 10:20 a.m. revealed both unlicensed staffs E and H were standing at the medication cart. Staff E removed medication packages from the cart then, while standing at the cart, popped each pill into a cup. She placed the packages into the cart. She took only the cup of medications to the resident's room and said aloud "I got your medications." Staff H accompanied staff E into the resident's room. The resident took the medications without help. Staff E returned to the cart and signed the medication observation record. Staff E did not take the medications, in their previously dispensed, properly labeled packages from the medication cart and bring them to the	A 052		

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A 052	Continued From page 10 resident. Staff E did not, in the presence of the resident, orally advise the resident of the medications' name and dosage and pop the prescribed amount of medication into a cup. The findings were discussed with staff E on .. .. at 10:40 a.m., at which time, she said she remembered learning the proper steps in her training class but, the way she did it during the observation was the way she was trained to do it on the previous day. Class III	A 052		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised	A 056		

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A 056	Continued From page 11 instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , . . . , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are	A 056		

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A 056	Continued From page 12 dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to make every reasonable effort to ensure medications were refilled in a timely manner to ensure doses were not missed for 1 of 3 sampled residents (#13). Findings: Resident #13's record revealed a facility admission date of . An 1823 health assessment form, dated , indicated the resident's diagnoses included , Body , and that the resident required assistance with self-administration of medications.	A 056		

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A 056	Continued From page 13 " with bodies (DLB) is a progressive, degenerative of unknown . Affected patients generally present with preceding motor signs, , , with visual and episodes of reduced responsiveness." (reteived emedicine.medscape.com/article/1135041). Observations made during a medication pass for the resident on at 10:20 a.m. revealed the resident did not receive his , an , medication and cream, an medication. Resident #13's medication observation record revealed "9" was documented on and for both , and cream. The chart codes indicated "9" meant "other/see progress notes". The resident's progress note of indicated both , and creeam were being ordered that night. Documentation, dated , indicated both medications were enroute from the pharmacy. Review of medication reorder forms revealed a refill was requested from the pharmacy on at 3:20 p.m. The pharmacy's response was "no refills". A reorder form revealed a refill for both medications was requested on at 11 p.m. The resident's record did not contain documentation that indicated any additional efforts were made to obtain a refill for , when the facility was informed there were no refills, and no documentation that indicated the facility made any efforts, prior to , to	A 056		

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	AL11969591	A. BUILDING: _____ B. WING _____	03/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERTUS WL OPCO LLC	11120 LAKE UNDERHILL ROAD ORLANDO, FL 32825

(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 056	Continued From page 14 obtain a refill on . . .. cream. On . . . . at 3 p.m., the Director of Nursing confirmed the findings and was unable to provide additional documentation. Class III	A 056		
A 086 SS=D	59A-36.011(10) FAC Training - ADRD (10) .... AND RELATED ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between , . and , , shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled " . . . . . and Related Level I Training," must address the following subject areas: 1. Understanding . 's and related . . . . . ; 2. Characteristics of . ; 3. Communicating with residents with . . . . 's ; 4. Family issues;	A 086		

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A 086	Continued From page 15 5. Resident environment; and, 6. Ethical issues. (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility and Related . . . . . Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related . . . . . Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. and Related Level II Training must address the following subject areas as they apply to these : 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with 's . . . . . and Related ," dated , incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to	A 086		

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A 086	Continued From page 16 meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with or related , or 2. Three years of practical experience in a program providing care to persons with or related , or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with or related . (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g).	A 086		

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A 086	Continued From page 17 This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure that 1 of 5 sampled staff (C) had completed the four-hour Level 1 and Related (ADRD) training within 3 months of employment, and the facility failed to ensure that 1 of 5 sampled staff (B) completed the four-hour annual ADRD update training as required. Findings: 1. Staff B's personnel record review revealed a hire date of . . . . The Level 1, four-hour training was completed on and Level 2, four-hour training was completed on . Staff B again completed both Level 1 and Level 2 ADRD trainings totaling 8 hours on . There was no documented evidence that the four-hour annual ADRD update training was completed. 2. Staff C's personnel record review revealed a hire date of . . . . There was no documented evidence of the four-hour Level 1 ADRD training was completed. The training was due in . On at 3:20 PM, the Business Office Manager stated that she would look in another file they kept in the office with trainings completed. On at 4:05 PM, the Administrator stated he could not find the trainings and confirmed the findings. Class III	A 086		