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
	AL11969626	A. BUILDING: _____ B. WING _____	04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRIVE AT FERN PARK	7255 STRIVE PL FERN PARK, FL 32730

(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 #2022004976 was conducted on . . . . . The facility had a deficiency at the time of the visit.	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 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 record review and interviews the facility failed to provide care and services appropriate to the needs of residents and did not answer call lights timely for a resident needing assistance with toileting (t#1). Findings: In a review of resident#1's health assessment it revealed the resident needs assistance with ambulation, bathing, [illegible], toileting and transferring. In review of facility notes for resident #1 dated late entry [illegible] states on [illegible] resident #1 summoned the staff via call light and could not	A 025		

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A 025	Continued From page 2 find anyone to assist with toileting. Resident attempted to call staff on the phone and could not get an answer. The resident called law enforcement. When the officer arrived at the community, he could not locate any staff and called the Chief Financial Officer to alert them of the situation. In review of the facility's call light log for the month of dated at 9:51pm the response time was 1 hour and 1 minute, on at 3:57pm the response time was 1 hour and 8 minutes, on the response time was 1 hour and 5 minutes. On the call log revealed resident #1 pushed the call light at 3:25 am and there was no response for 2 hours and 13 minutes. In an interview on at 7 am with resident #1 she confirmed that she needed assistance that morning with toileting and bathing, and no one answered her call light, and she could not find anyone in the building to assist. She stated that is when she called law enforcement and she could not find any staff either. She stated this has happened in the past and continues to be on going. In an interview with resident #1's family member on at 12pm she confirmed her mother has been complaining of the facility being short staffed and not being able to assist her when needed. She stated she is aware of the incident and stated the facility has not done anything to correct the short staffing. In an interview with staff F on 12:30pm, She stated she had gotten approved to leave at 1am that day because a coworker was going to take her place. She found out during her	A 025		

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A 025	Continued From page 3 shift that the staff who was to replace her could not make it. She stated she called the Director of Nursing, but he never called her . . . . She stated she left at 1:30 am without anyone replacing her and that left one staff in the assisted living. In an interview with the Director of Nursing on at 9am, he confirmed he oversees the caregiver schedules and if there is no one to cover a caregiver's shift he comes in to replace them. He confirmed he received a call from staff F that morning but did not call her and did not come in to replace her. He stated she should not have left her shift without being replaced. He stated resident #1 called law enforcement because there was no staff to assist her. He stated he did an in-service with the staff that week to go over call light response, nursing cell protocol and shift replacement. He stated the facility is process of hiring an overnight nurse who will float from assisted living to memory care. In an interview with the administrator on . . . . . at 1pm she confirmed the above findings. Class III	A 025		