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
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. ROAD JACKSONVILLE, FL 32257

(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
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to register 2 of 10 sampled employees, and 7 unsampled employees, in the facility's Background Screening Clearinghouse roster within 10 business days of employment. The findings include:	CZ814		

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
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. [redacted] ROAD JACKSONVILLE, FL 32257

(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
CZ814	Continued From page 1 Review of personnel files revealed that Employee C, Med Tech, was hired on [redacted] and Employee H, Med Tech, was hired on [redacted]. Review of the Background Screening Clearinghouse revealed that these employees were added to the roster on [redacted]. Photographic evidence obtained. In an interview on [redacted] at 1:45 PM, the Business Office Manager confirmed that Employees C and H were added to the roster on [redacted]. She provided a written statement with a total of 9 newly hired staff that were not added to the roster. Photographic evidence obtained. She stated that she was waiting for staff to complete the training, and she forgot to add them to the roster. She confirmed at all the nine employees have been providing direct resident care. Unclassified	CZ814		

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
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. ROAD JACKSONVILLE, FL 32257

(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 (complaints #2022004825, 2022004510 & 2021017340) was conducted at Wyndham Lakes Jacksonville on , , 2022. Deficiencies were identified at the time of the survey.	A 000		
A 030 SS=H	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. [illegible] ROAD JACKSONVILLE, FL 32257

(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 030	Continued From page 1	A 030		

and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. [illegible] and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and [illegible];
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical [illegible].
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where

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
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. [redacted] ROAD JACKSONVILLE, FL 32257

(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 030	Continued From page 2 residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from [redacted] and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as	A 030		

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
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. ROAD JACKSONVILLE, FL 32257

(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 030	Continued From page 3 provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. [illegible] ROAD JACKSONVILLE, FL 32257

(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 030	Continued From page 4 relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without [illegible], interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, [illegible], and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and, if applicable, [illegible], Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. . . . . ROAD JACKSONVILLE, FL 32257

(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 030	Continued From page 5 must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and . . . . , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to protect the residents' rights to a safe and decent living environment following a staff to resident case which affected three of eight sampled residents (Residents #2, #3, and #8). The facility also failed to ensure the right to adequate and appropriate healthcare by failing to follow through on its own policies and procedures for one of seven employees sampled, following a pattern of	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. [illegible] ROAD JACKSONVILLE, FL 32257

(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 030	Continued From page 6 noncompliance with facility medication procedures (Employee D). The findings include: Review of the grievance logs from [illegible] to [illegible] revealed two grievances filed against Employee B on [illegible] by the family members of Resident #1 and Resident #2. (Photographic evidence obtained) In an interview on [illegible] at 4:02 PM, Resident #2 confirmed that Employee B told her she left her in bed, "because she was fat." She added that she was told Employee B was fired. She mentioned that she felt defeated, and started crying. During an interview with the Administrator and the Resident Services Director ([illegible]) on [illegible] at 5:06 PM, the following incidents were reviewed. On [illegible], Resident #1's daughter provided the Memory Care Director a written statement of the incident regarding resident [illegible]. The statement explained that on [illegible], she was visiting her mom who was receiving end of life care and found out that her mom was gotten out of bed even after hospice nurse requested the resident be returned to bed due to her condition. She wasn't put [illegible] to bed until the on-coming 3pm to 11pm shift came on duty. She also documented that on around 12:00 PM, she witnessed Employee B using the medication cart to [illegible] residents from walking down the hallway and anyone that attempted to get out of their seat was told to sit [illegible] down. Employee B was heard yelling to Resident #8 who was attempting to go to another resident's room. She also observed Employee B refusing to provide a jacket to Resident # 3 who	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. [illegible] ROAD JACKSONVILLE, FL 32257

(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 030	Continued From page 7 had complained of being [illegible] several times. Employee B then started reprimanding Resident #3 for his [illegible] and refused to assist with cleaning him up. As the Administrator was her initiating investigation into the events from [illegible], Resident #2's daughter walked into her office and stated that during her visit on [illegible], Resident #2 said that Employee B told her she could not get her out of bed as she was too fat. They explained that Employee B was suspended on [illegible] pending investigation, and later terminated on [illegible]. Employee D, Med Tech, who was also assigned to the memory care unit, was suspended on [illegible] and reinstated on [illegible] as there was not enough evidence produced in their investigation to show she was involved with the incidents with Employee B. Review of Resident #2's Resident Health Assessment for Assisted Living (AHCA form 1823) dated [illegible] revealed she had a history of [illegible] and needed assistance with [illegible], self-care, toileting, and transferring. (Photographic evidence obtained) Review of Resident #3's 1823 dated [illegible] revealed a diagnosis of [illegible]. He had a history of atrophy in the lower [illegible], and needed medication administration and activities of daily living (ADL) support. The resident was also documented as a [illegible] risk and required supervision with self-care, toileting, [illegible] and transfer. (Photographic evidence obtained) Review of Resident #8's 1823 dated [illegible] revealed a history of [illegible]'s/[illegible],	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. ROAD JACKSONVILLE, FL 32257

(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 030	Continued From page 8 advanced , very limited words, and deteriorated gait mobility. Resident #8 was documented as a risk who relied on staff to assist with bathing, , self-care, and toileting. (Photographic evidence obtained) Review of the facility's policy and procedure titled GP 10 - dated mandated, "Residents shall be free from any physical obstruction of movement. Physical obstruction of movement includes but not limited to being personally involved or having used a material item for a.) blocking a resident's pathway; b.) restricting a resident from the freedom to or getting out of bed; c.) Prevention of a resident's movement to and from one area; d. Restraining or blocking a resident in a sitting or lying position." (Photographic evidence obtained) On at 11:25 AM, Employee D was observed assisting residents with self-administration of medication. In an interview at 11:28 AM, Employee D confirmed getting suspended for one day. When asked if she witnessed anything between Employee B and residents, she stated that on , during lunch, Employee B was observed being aggressive to Resident #7. She stated that she did not report this to anyone. Employee D was then asked to explain the process for controlled medication reconciliation. She stated that are counted at the end of every shift. After verifying the count, the off-going and the on-coming med tech signs the controlled medication count form. If the count is off, the nurse on duty or the Resident Service Director ( ) gets notified. Normally, the off-going med tech is not able to leave the facility	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. ROAD JACKSONVILLE, FL 32257

(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 030	Continued From page 9 until it the issue is rectified. Employee D denied being involved in discrepancy, but then continued to explain a time when she was told her cart had a discrepancy with the medication. She added that the nurse corrected the error, and " I think she just had to indicate that one dose was wasted." The facility's policy and procedure titled Controlled medications dated read, " The community supports and enforces safe process for the management, storage, and administration of controlled substance medications. Scheduled II medications have special descriptive requirements. Precautions will be enforced to ensure that all controlled substances have been properly accounted for and destroyed as indicated to prevent drug diversion". The policy also indicated that when a dose of a routine or as needed (PRN) controlled substance is removed from the original packaging, it is also documented on the controlled substance control form including the: Date, time, quantity used, quantity remaining and initials. The policy further indicated that shift counts are performed at the end of each shift when the person responsible for medications changes. This includes breaks, mealtimes etc. Whenever a Med Tech leaves the floor, and another med tech is responsible for meds a complete count will take place by the person going off and the person coming in on the cart. If the quantity is verified, the off-going and on-coming Med Techs both sign the appropriate controlled substance shift count form. The controlled substance count sheets or the bound book provided by the pharmacy may be used. If the quantity differs: a. The off-going and on-coming Med Techs will perform a recount to ensure a simple counting	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. ROAD JACKSONVILLE, FL 32257

(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 030	Continued From page 10 error was not made. b. Check the MOR or PRN record to see if the medication was used and not noted on the controlled substance control form. If this is the case the on-shift Med Tech must make a notation on the controlled substance control form of the use of the medication and initial, it. c. If the count was correct and the medication was not used according to the MOR or PRN record, this must be documented on the Controlled Substance Shift Count form and the Executive Director notified immediately. Review of personnel actions taken by the facility showed that Employee D was counseled in , for failure to follow procedures on counts and reporting medication errors. In , she was counseled for leaving a resident before watching to ensure all medications were taken and leaving crushed medications out on her cart unattended. The unattended medications were taken by the wrong resident, and he had to be hospitalized. In , she was counseled for additional med pass errors including giving the same medication twice, her count being off, and not documenting correctly. A letter dated was in Employee D's file stating an allegation of neglect was made against her and she was suspended from until at 6:45 AM to "ensure that you understand the seriousness of this situation and to convince you of the need to correct the problem." (Photographic evidence obtained) In an interview on at 12:00 PM, the was asked to review the disciplinary actions contained in the Employee D's personnel file. She confirmed the information from , when Employee D left crushed medications belonging	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. ROAD JACKSONVILLE, FL 32257

(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 030	Continued From page 11 to Resident #5 unattended on the medication cart. Resident #6 took them. The explained Employee D was educated on the seven rights of medication administration. On , the stated Employee D had discrepancies in the count for , sulphate (controlled medication). When asked if the employee reported the error herself, she stated no, the error was identified by a different employee on the following day during count. When asked if law enforcement was notified, she stated no. confirmed that that law enforcement should have been informed. When asked the corrective actions taken by the facility, the stated Employee D was taken off the medication cart. There was no timeline on when Employee D would resume medication technician duties. She confirmed that on , Employee D was assigned medication technician duties. When asked about the facility's policy on discipline and conduct, she stated that after three warnings, employees should be terminated. When asked how many warnings Employee D had received. The replied, "5 warnings." She was then asked why Employee D wasn't terminated, and she stated corporate made the decision to reinstate the employee. Review of the facility's Employee handbook dated , , Page 57, Section , "Progressive Discipline" read, "Pacifica supports the use of progressive discipline based on employee's specific assignment to address conduct issues such as poor work performance or misconduct. This encourages employees to become more productive workers and comply with Company standards and expectations. Generally, a supervisor gives a warning to an employee to explain behavior that the supervisor has found	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. [redacted] ROAD JACKSONVILLE, FL 32257

(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 030	Continued From page 12 unacceptable. A progressive discipline step include verbal written and final warning. However, Pacifica, reserves the right to immediately terminate an employee if the situation warrants." (Photographic evidence obtained) In an interview on [redacted] at 12:41 PM, the Administrator was asked about Employee D. She reviewed the employee file and confirmed there was an issue with discrepancies in [redacted]. She confirmed that law enforcement was not contacted. When asked about Employee D's conduct, she confirmed that the staff has had multiple disciplinary action ranging from call offs to med errors. She also confirmed Employee D was recently suspended due to allegation of [redacted], and later reinstated as there was not enough evidence that she did anything wrong. She was informed of the additional allegation against Employee B shared by Employee D that was never reported to administration. The Administrator stated that she was not aware of the incident regarding Resident #7 that Employee D did not report. She did not conduct staff interviews about Employee B's behavior and did not conduct any assessments on residents involved and acknowledged she should have done more of an investigation. She stated that that the decision to reinstate the employee was made by the corporate. Disciplinary actions were for different mistakes. Review of the facility's policy and procedure titled GP 09- Elder , Neglect, and , dated [redacted] indicated the following procedures to be taken: "All Personal Care Assistants will receive in-service training on elder incidences signs and symptoms of , and reporting requirements during initial orientation. This training shall be repeated per	A 030		

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
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. ROAD JACKSONVILLE, FL 32257

(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 030	Continued From page 13 state regulations. All staff and volunteers at Pacifica Senior Living are " mandated reporters." If any community staff member or volunteer has observed, suspects, has knowledge of, or is told by a resident or other staff member, of an incident which appears to be any form of the incidence will be immediately reported to the Resident Care Director. If the resident care director is not available, the incident will be reported to the executive director. In all cases the Executive Director will be informed as soon as possible. Upon the notice of reported, observed, suspected, or at imminent risk of any form of : a). immediate steps will be taken to ensure the resident is protected from potential future and neglect while the investigation is being conducted. b.) A thorough investigation will be conducted by the Resident Care Director of Executive Director." (Photographic evidence obtained) Class II	A 030		
A 165 SS=E	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.	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. [illegible] ROAD JACKSONVILLE, FL 32257

(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 165	Continued From page 14 (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. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] 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; 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	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. ROAD JACKSONVILLE, FL 32257

(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 165	Continued From page 15 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 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:	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. [illegible] ROAD JACKSONVILLE, FL 32257

(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 165	Continued From page 16 Based on interview and record review, the facility failed to ensure a reportable incident was filed in a timely manner to the Agency for Health Care Administration (AHCA) for one of eight sampled residents (Resident #6) following an event that caused him to be discharged to a higher level of care. The finding include: Review of personnel records for Employee D, Med Tech, showed she was counseled in [illegible] for leaving crushed medications out on her cart unattended. The unattended medications were taken by the wrong resident and he had to be hospitalized. In an interview on at 12:00 PM, the Resident Service Director ( ) was asked to review the disciplinary actions contained in the Employee D's personnel file. She explained that on , Employee D left the crushed medication belonging to Resident # 5 unattended on the medication cart. Resident #6 accessed the medications and took them. The Physician was notified and ordered to send the resident to an acute care hospital for evaluation. When asked the actions were taken by the facility following the incident, she stated that Employee D was educated on the seven rights of medication administration. The stated that an adverse incident was not completed. Review of the facility policy and procedure titled GP 18- Internal Incident Report and State Incident Report dated indicated that Injury and unusual incidences will be reported in compliance with state regulatory requirements. Every facility is required to maintain adverse incidence reports. For the purposes of this	A 165		

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
	AL11963719	A. BUILDING: _____ B. WING _____	04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDHAM LAKES JACKSONVILLE	10660 OLD ST. [redacted] ROAD JACKSONVILLE, FL 32257

(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 165	Continued From page 17 section term , "adverse incident means": an invent over which facility personnel could exercise control rather than as a result of the resident's condition that results in; 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 an event that is reported to law enforcement or its personnel for investigation. Review of the Adverse Incident Reporting system showed that as of [redacted], no report was filed regarding the incident with Resident #6. Class III	A 165		