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
	AL11969507	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DISCOVERY VILLAGE AT DEERWOOD	10520 VALIDUS DR JACKSONVILLE, FL 32256

(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 #2022005729, was conducted at Discovery Village at Deerwood on and . Class I deficient practice related to Resident Rights was identified at the time of the survey.	A 000		
A 030 SS=L	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		

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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

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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 . . . . . 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		

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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		

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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 , 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, , 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 Hotline operated by the Department of Children and Families, and, if applicable, , 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		

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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 interview and record review, the facility failed to honor their residents' right to live in a safe and decent living environment, free from neglect, for one of three residents sampled who experienced a change in condition, Resident #1. Additionally, the facility failed to ensure staff were knowledgeable in protocols to respond to residents in distress, placing all residents at risk of not receiving adequate and appropriate health care should they also experience a change in	A 030		

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A 030	Continued From page 6 condition. The findings include: Record review of the facility's policy titled "Change of Condition" and dated , , stated that significant changes in physical or condition will promptly by reported to the Health Care Provider. It went on to explain the nurse or provider was to report the change to a supervisor and have a nurse evaluate the change. Photographic evidence obtained. Record review of the facility's policy titled " " ( ) dated indicated a copy of the resident's advance directives were to be maintained in the resident's medical record. There should also be a notation in the record to the fact that the advance directive exists. Residents that had an executed order are identified by chart sticker stating " ." Photographic evidence obtained. Record review revealed Resident #1 moved into the facility on . Her 1823 Health Assessment detailed her diagnoses as , and a prior history of . Progress notes for Resident #1 showed a monthly summary documented from , and , then a note from authored by Employee A, a Licensed Practical Nurse (LPN), which stated Resident #1 was found unresponsive in bed at approximately 11:20 am during rounds. She was last seen at 9:30am by care staff, in bed. 911 was called, as well as the fire department and law enforcement. Her time of was documented as 11:24 am. The note indicated the primary care physician and responsible party were notified. Photographic evidence obtained.	A 030		

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A 030	Continued From page 7 An interview was held with the Health and Wellness Director (HWD) at 12:40pm on in which she stated she was working with the facility's regional nurse to go through policies and was not aware of any issues regarding code status. During an interview on . . . . . at 12:54 pm with the Administrator, when asked about advanced directives, she stated, "We try to collect it upon signing and sometimes they bring it in when they physically move. If they don't complete the , then it's treated as a full code." She explained a resident's code status could be found in the resident's chart. When asked about the facility's policy she stated she saw the book of policies but did not review any of them with the regional representative, adding, "I wasn't aware that it was a requirement to be familiar with the advance directives" and that she was unsure of where the was listed. During an interview on at 1:09pm with Employee A, Licensed Practical Nurse (LPN) and Unit Manager, she stated she had been employed with the facility "since the doors opened" (several years ago.) She stated she primarily worked in the memory care unit and was familiar with Resident #1. She explained that Resident #1 expired in the facility. Employee A stated she was notified by Employee B that Resident #1 was ". . . and blue" so she went to Resident #1's room and checked for a , , but couldn't find one. Employee A stated she noticed that Resident #1's skin was blue along the dependent side of her . . . and along the dependent side of her left arm. Employee A stated that Employee B told her the resident was "stiff." Employee A confirmed that she did not	A 030		

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A 030	Continued From page 8 assess for the onset of [illegible] and stated, "I took her [Employee B's] word for it" and did not initiate [illegible]. She confirmed the chart for Resident #1 did not indicate she had an executed [illegible] on file. Employee A stated she doesn't perform [illegible] if the resident "is obviously [illegible]." Employee A again confirmed that she did not assess for [illegible]. Employee A stated that "for about a week prior" to her [illegible], Resident #1 had a change in condition, evidenced by pulling pictures off the wall and putting her laundry and things out in the hallway. When asked whether a physician had been notified of the change in condition, Employee A stated, "No," but explained that when a resident had a change in condition, "The nurse should definitely assess whatever it is and let the doctor know." During an interview on [illegible] at 1:47 pm with Employee B, a caregiver, she stated that she had worked at the facility for about a year and was familiar with Resident #1's care. Employee B explained that around 7:30am on [illegible], she went into the room and observed Resident #1 lying in bed beside her husband. She stated Resident #1's husband told her at that time that Resident #1 "had a rough night" so they just wanted to sleep in. She further explained that she went [illegible] into the room around 9:45am and both of the residents were sleeping so she left the room. Around lunch time Employee B again went into the room and noticed some discoloration "that looked like a [illegible]" on the left side of Resident #1's [illegible]. Employee B stated she notified Employee A, the LPN. Employee A responded to the room and checked for a [illegible] but did not initiate [illegible]. She stated 911 was called. Employee B stated that Resident #1 had been displaying increased [illegible] for	A 030		

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A 030	Continued From page 9	A 030		

approximately a week prior to her . . . . . She stated, "I don't know what was going on with her, but she was pulling pictures off the walls and putting all her stuff out in the hallways." When asked whether she had reported any of these changes to anyone, she stated Employee A, the nurse, was made aware. Employee B was asked about the facility's process for advance directives. She stated, "We do not know who the . . . are. We are certified to do , but the nurse has to find out if they are a ."

An interview was conducted on . . . . . at 1:59pm with Employee F, a caregiver employed at the facility for approximately 1 year. When asked what she would do if a resident has a change in condition or if a resident was found unresponsive, she stated she would report it to the nurse, Employee A. She did not know how to locate a resident's code status and did not know what a was. When asked if she received training, she answered, "No. We can't give them . . . . to . . . . , we have to run and get help." Employee F explained all of the charts were in Employee A's office.

During an interview on . . . . . at 2:48 pm with the HWD regarding the facility's processes for . . . . . a resident's change in condition, she explained that the nurse should conduct "some sort of assessment and contact the physician." When asked whether she was aware of any changes in condition for Resident #1, she explained that the nurse on duty the night of Resident #1's passing later described (and later charted) a behavioral change in condition and offered to transfer Resident #1 to the hospital. When asked whether the physician was contacted or any other interventions were implemented related to the change in condition,

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A 030	Continued From page 10	A 030		

she stated, "If it was done it would have been charted. I don't know." Review of the medical record for Resident #1 revealed no documentation of any change in condition in , , , any follow-up assessment, or notification to a physician. Photographic evidence obtained.

Forms titled "Team Member In-Service Training Record" detailed an inservice dated from 2:00pm-3:00pm, led by the HWD. The , indicated the subject matter included code status, resident rights, and the facility's policy and procedures for . Employees A, B, D, F, G, I, and the Administrator were listed in attendance. Photographic evidence obtained.

During an interview on at 3:09 pm with Employee D she confirmed that she was working on the day of Resident #1's . She went into the room at about 9:45am. She stated Resident #1 "was still breathing when I went in there. Her husband was holding her and said they didn't want to get up yet so I just left the room." Employee D stated Resident #1's memory "was getting worse for like a week" and that she thought the nurse had been notified by someone else. When asked about the facility's process for responding to changes in condition, Employee D stated, "We just tell the nurse and the nurse is supposed to call the doctor." Employee D stated she would ask the nurse what a resident's code status was, and she could not explain what a was. When asked about the staff meeting conducted by facility management on , Employee D confirmed she attended the meeting and added, "We just talked about getting a raise and something about a survey but I'm not sure." When asked whether any content regarding advance directives, , or changes in condition were discussed, Employee D stated,

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A 030	Continued From page 11 "No." Employee I was interviewed on at 3:38 pm. She was asked about the details of the inservice from and stated they introduced new staff members, and received updates from different departments, but did not discuss code status. At 4:58pm on , Employee E was interviewed via telephone. She explained Resident #1 had been complaining of on , so she alerted Employee C, LPN. Employee C confirmed this during an interview on at 5:21 pm. She explained that around 8:30 pm on , she was told that Resident #1 was complaining of underneath her , so she assessed the area. She stated the resident didn't have any medication ordered, and offered to send the resident out to the emergency room, but the resident's husband declined. Resident #1 did not take any medications at night and the she complained of appeared to be under the , right across the , as she described the as "underneath her ." Employee C alleged that she took the resident's vitals and that they were within normal limits, however this was not documented and she could not recall the results. She stated that she was aware of the resident's change in condition but didn't deem it significant enough to notify the physician about it. Progress notes for Resident #1 showed she had vitals documented after a in , after a in , and after an illness in . No vitals were documented in her record past . There were no	A 030		

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A 030	Continued From page 12 notes to show Resident #1 was assessed by Employee C following complaints of the , on , or that any physician was notified. Photographic evidence obtained. Physician orders for Resident #1 included an order written for , tablet 500 mg to be taken by every four hours as needed for , . Photographic evidence obtained. Resident #1's APRN (Advance Practice Registered Nurse) was interviewed on at 11:45am via telephone. She was unaware of any changes in condition prior to her . The APRN stated she was told Resident #1 had breakfast that morning, and returned to her room with her spouse. She then laid down for a nap and was found . She received the report from Employee A. She confirmed there was an active order for , . She stated Resident #1 was full code and the expectation was that would be performed if a resident did not have an executed . The Administrator was interviewed on at 3:13 pm. She was asked about her staff's lack of understanding about code status and the lack of response to Resident #1's change in condition. She stated she herself was unfamiliar with the facility's policies and procedures about changes in condition. In a follow up interview on at 4:33 pm, she was asked about any investigation into the events surrounding Resident #1. She did not see the need to investigate based on information that was provided to her, and called it "cut and dry with no corrective action required." She stated Employee A told her today ( ) that Resident #1 was provided , medication by Employee C.	A 030		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969507	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DISCOVERY VILLAGE AT DEERWOOD	10520 VALIDUS DR JACKSONVILLE, FL 32256

(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 Review of the position description for a caregiver showed they were responsible for providing on care, and "maintaining a safe and comfortable home like environment." They were to observe, report, and document "symptoms and conditions of residents for changes in condition such as skin, behavior, alertness, , dietary, and participation in activities." They were also to notify their supervisor if a resident had increased care needs. Photographic evidence obtained. CLASS I	A 030		