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
	AL11968384	A. BUILDING: _____ B. WING _____	05/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER AT ASSISTED LIVING FACILITY	1773 HAYS ST PALM BAY, FL 32907

(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 Complaint Investigation #2022003261 was conducted on . . . . . Tender at . . . Assisted Living Facility had deficiencies at the time of the survey.	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 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	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 59A-36.012, F.A.C. (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 reviews and interviews, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision when 2 of 4 sampled residents , one on top of the other, resulting in one of the resident's sustaining a , (#1 & #2), and failed to provide adequate supervision when 1 of 4 sampled residents choked another resident (#1 & #5). Findings: 1. Resident #1's record revealed a facility admission date of . An 1823 health assessment form, dated , indicated the	A 025		

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A 025	Continued From page 2 resident's diagnoses were , type 2, , and that the resident's cognition was moderately . A facility note, dated , indicated the resident was taken to a health care provider due to aggressive behavior and not sleeping at night. A facility note, dated , indicated the resident in the kitchen, then complained of , in a location not specified in the note. Emergency Medical Services ( ) was called and upon arriving to the facility, determined the resident did not have to be transported to the hospital. A facility note, dated , indicated the resident was taken to a health care provider because the increase in medications was not working, on a condition that was not specified in the note. A facility note, dated , indicated the resident was aggressive towards both residents and staff. The resident tried to choke another resident on the previous day and threw a garbage can cover at staff. The resident was grabbing things off a table when resident #2 tried to stop her. Resident #1 pushed resident #2 then on top of resident #2. The facility note indicated that resident #2 appeared to have a . A facility note, dated , indicated the resident was taken to a health care provider due to the incident and medication follow-up. A facility note, dated , indicated the resident was discharged from the facility.	A 025		

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A 025	Continued From page 3 2. Resident #2's record revealed a facility admission date of . A current 1823, dated , indicated the resident's diagnoses were Displaced of Right , Hypoxic , Acute Failure, , Major , and . An 1823, dated , indicated the resident required precautions. An 1823, dated , indicated the resident's or behavioral limitations was " ". A facility note, dated , indicated staff reported that resident #1 onto resident #2's , and the , appeared to be . was called and the resident was transported to the hospital. A facility note, dated , indicated resident #2 was readmitted to the facility following a stay in a rehabilitation facility. Review of a facility incident report revealed that on at approximately 3:30 p.m., resident #1 was in the kitchen.When resident #2 attempted to redirect resident #1 out of the kitchen, both of them and resident #1 landed on top of resident #2. Resident #2 was unable to move and complained of , to an area that was unspecified on the report. responded and transported resident #2 to the hospital where an , revealed a , . The report indicated the facility's analysis of the incident: resident #1 was trying to turn on the stove when resident #2 attempted to redirect resident #1 out of the kitchen by holding resident #1's and walking backwards. Resident #2 backwards	A 025		

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A 025	Continued From page 4 onto the kitchen floor and pulled resident #1 down with him. Review of a hospital history and physical, dated [redacted], revealed resident #2 was admitted to the hospital with a diagnoses of a right [redacted]. 3. Resident #5's record revealed a facility admission date of [redacted]. An 1823, dated [redacted], indicated the resident's diagnoses was major [redacted]. During an interview with resident #5 on [redacted] at 12:58 p.m., she said resident #1 choked her on [redacted]. Resident #5 said resident #1 placed her [redacted] around her [redacted], then pushed her backwards, which caused her to [redacted]. Resident #5 said she did not sustain injuries from either the choking or the [redacted]. Resident #5 said resident #1 was very violent and described an incident where resident #1 removed a plant from somewhere, then took it into another resident's room. Resident #5 said she went into the resident's room to retrieve the plant when resident #1 slammed the room door, then grabbed a wooden stick and hit resident #5 three times on her [redacted]. Resident #5 said she did not sustain injuries from being struck with the stick. Resident #5 said she witnessed the incident involving resident #1 and resident #2 and said resident #1 was getting into everything in the kitchen, so resident #2 tried to grab her, at which time, both residents began wrestling, then resident #1 [redacted] on top of resident #2. Resident #5's record did not contain documentation to indicate the resident was choked by resident #1. During a phone interview with resident #2 on [redacted] at 12:26 p.m., he was asked about his	A 025		

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A 025	Continued From page 5 on . . . . . . The resident replied that he did recall that something happened then said, "I think somebody . . on top of me or something. I didn't see anything. I was out. They [staff] told me what happened." During an interview with the facility administrator on at 1:15 p.m., she said that prior to the . . . involving residents #1 and resident #2 on , resident #1's behavior was such that she was constantly on the go, often picked things up, and was difficult to redirect. The administrator said changes were made to resident #1's medications however, it did not improve the behaviors. The administrator said that she never saw resident #1 be violent with others. The administrator said that caregiver C, who was the staff member working on , reported that when the two residents . . , the caregiver was out of sight in the front room sorting medications. During an interview with the administrator on . . . . . at 1:25 p.m., she said a note regarding the choking incident with resident #1 and resident #5 was not written in resident #5's record because "it was just mentioned by caregiver C that it happened on the day before." During a telephone interview with caregiver C on at 1:50 p.m., she was asked about the involving resident #1 and resident #2. She said, "I can't give any information." The caregiver was asked to repeat what she said, and she replied, "I don't know what's going on right now", then ended the call. Class II	A 025		

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CZ814	Continued From page 6	CZ814		
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , 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 , 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; ; 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 review of the facility's background screening clearinghouse roster and interview, the facility failed to report the employment status for 1 of 6 sampled staff within 10 business days (B). Findings:	CZ814		

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CZ814	Continued From page 7 Review of the facility's and , staff schedules on . . . . . at 12:12 p.m. revealed caregiver B was a live-in caregiver during all of and , ...The administrator said the schedules were accurate and that caregiver B worked at that time. Review of the facility's clearinghouse roster on at 12:38 p.m. revealed caregiver B was not listed on the roster, as required. Unclassified	CZ814		