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 _____	08/05/2022

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 Complaint Investigation #2022011221 and a Generator Monitoring were conducted on , , and . Strive at Fern Park had a deficiency at the time of the survey.	A 000		
A 076 SS=J	59A-36.009 FAC ( ) (1) POLICIES AND PROCEDURES. (a) Each assisted living facility must have written policies and procedures that explain its implementation of state laws and rules relative to ( ). An assisted living facility may not require execution of a as a condition of admission or treatment. The assisted living facility must provide the following to each resident, or resident's representative, at the time of admission: 1. Form SCHS- , "Health Care Advance Directives - The Patient's Right to Decide," , or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in chapter 765, F.S. Form SCHS- is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308 or the agency's website at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and, 2. DH Form 1896, Florida Form, , 2004, which is hereby incorporated by reference. This form may be obtained by calling the Department of Health's toll free number 1(800)226-1911, extension 2780 or online at: http://www.flrules.org/Gateway/reference.asp?No	A 076		

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A 076	Continued From page 1 =Ref-04005. (b) There must be documentation in the resident's record indicating whether a DH Form 1896 has been executed. If a DH Form 1896 has been executed, a yellow copy of that document must be made a part of the resident's record. If the assisted living facility does not receive a copy of a resident's executed DH Form 1896, the assisted living facility must document in the resident's record that it has requested a copy. (c) The executed DH Form 1896 must be readily available to medical staff in the event of an emergency. (2) LICENSE REVOCATION. An assisted living facility's license is subject to revocation pursuant to section 408.815, F.S., if, as a condition of treatment or admission, the facility requires an individual to execute or waive DH Form 1896. (3) PROCEDURES. Pursuant to section 429.255, F.S., an assisted living facility must honor a properly executed DH Form 1896 as follows: (a) In the event a resident experiences or , staff trained in , ( ) or a health care provider present in the facility, may withhold (and). (b) In the event a resident is receiving hospice services and experiences or , , facility staff must immediately contact hospice staff. The hospice procedures take precedence over those of the assisted living facility. This Statute or Rule is not met as evidenced by: Based on the facility's documentation, record review, and interview, the facility failed to honor the ( ) policies	A 076		

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A 076	Continued From page 2 and procedures for 1 of 4 sampled residents (#1). Findings: Resident #1's record revealed an admission date of . The last 1823 Health Assessment dated reflected a medical history including 's , , , and a history of . She needed assistance in all Activities of Daily Living (ADLs) except for being independent with eating. She needed assistance with self-administration of medications. The assessment revealed resident #1 did not have a ( ), and therefore required if needed per facility policy. Photographic evidence was obtained. Review of a submitted Agency for Health Care Administration (AHCA) report, dated , revealed that on at approximately 6:45 AM, resident #1 was found on her apartment floor unresponsive down by caregiver A when he went to assist her morning care. The policy's training agenda read that "Every resident admitted to the facility is presumed to have consented to (, , ,) unless a is written in the patient's medical record in a manner consistent with this policy." Photographic evidence was obtained. Resident #1 did not have a , therefore should have been performed immediately upon finding resident #1 unresponsive until the arrived. On at 4:18 PM, Caregiver A stated that when he found resident #1 unresponsive, he immediately turned resident #1 over and saw she was not breathing and was blue, started crying	A 076		

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A 076	Continued From page 3 and ran out of resident #1's room to get help from the Medication Technician (Med Tech) B. He stated he could not function emotionally or assist with anything; Med Tech B took over this situation. Caregiver A confirmed that he did not initiate because he was "no good with continuing to function" at his job during this time. Caregiver A stated this was the first time he ever seen a body. Facility notes revealed that on at 2 PM, the day before the incident, resident #1 was in good spirits, and that staff were still monitoring her post without injury from at 10:48 AM. Caregiver A's personnel record revealed a hire date of . The 1-hour training was completed on but there was no evidence of First Aid/ certification in the file. Med Tech staff B's personnel record review revealed hire date . The 1-hour training completed on . The First Aid/ certification expires . On at 11:25 AM, Med Tech B stated that on , she clocked in at 6:14 AM. She said Caregiver A told her that he would go assist resident #1 with , and grooming, getting her ready to go to breakfast. At around 6:30 AM, Caregiver A came running to her crying and upset, saying that resident #1 was . Med Tech B and Caregiver A both went to resident #1's room. Med Tech B checked resident #1 for a , and to see if she was breathing, but she was not breathing. She was blue in the and . Med Tech B said she started crying and called the Director of Nursing (DON) for guidance, and the DON told her to call 911 but	A 076		

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A 076	Continued From page 4 there were no other instructions. Med Tech B stated that she did not initiate on resident #1 because she was and upset, and in because she really cared about resident #1. Med Tech B stated that she had the training and First Aid/ certification but had simply forgotten the policies & procedures when handling this situation. On at 10:40 AM, the DON stated that Med Tech B called on about 6:30 AM and told him that resident #1 was found in her room by Caregiver A. The DON instructed Med Tech B to call 911 but gave no further instructions to check for a and to start on resident #1. The DON stated he called the physician and family member to inform them that resident #1 had , , about 7:25 AM that morning. On at 11:50 AM, the Chief Operating Officer (COO) provided the Seminole County Sherriff's Police Report #2022CJ014029. The COO stated that she came to the facility around 8:30 AM and was told by staff that Emergency Medical Services ( ) arrived around 6:50 AM but did not do , that just looked at resident #1 and said she was . On at 2:04 PM, a telephone interview with the COO confirmed the findings. Class I	A 076		