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
	AL11969817	A. BUILDING: _____ B. WING _____	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE ON THE GREEN	515 VILLAGE PL LONGWOOD, FL 32779

(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 #2022006062 and generator monitoring was conducted on [redacted] and on [redacted] at Village on the Green, Longwood. A deficiency was found at the tie if 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 [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 [redacted] 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	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 resident diets in accordance with Rule 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 review and interviews the facility failed to provide care and supervision for a resident left unsupervised during an activity that left Elmer's dement glue out in the proximity of an unsupervised resident for 1 of 3 resident (#1. Findings: In a review of resident#1's health assessment it revealed a medical history of 's [illegible], high [illegible]. Alert and oriented x 2 with and forgetfulness,	A 025		

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A 025	Continued From page 2 precautions and hospice recipient. Resides in memory care. In review of the agency's internal report dated [redacted] reveals resident#1 was sleeping in his room during a craft activity which was taking place in the common area. Activity staff person had to leave the table unattended and informed the residents participating to come [redacted] after lunch. Resident came out of his room before staff was able to come [redacted] to the activity table to clean up the supplies left on the table. Resident was then noticed with the glue bottle in his [redacted]. Resident was sent to the emergency room and had no residual effect, and no treatment was given. In review of the facility observation note dated [redacted] it states at approximately 3:50 pm on [redacted], resident was observed by nurse standing next to the activity table where residents had been doing a craft activity. Nurse noted the resident had picked up a bottle of Elmer's rubber cement glue from the table and had it in his [redacted]. Nurse removed the bottle from residents' [redacted] and noted liquid in his [redacted]. Resident swallowed the glue and then spit out the rest on the floor. Resident was sent to Emergency room at 6:30pm. In an interview on [redacted] at 11:30am Staff E stated she saw the activity person at the table doing activities. She stated she herself went to do her duties. At some point the activity was over and the residents left the table and went with the 2 other caregivers who were watching a movie with the residents and the activity person was not around and the supplies were still on the table. She stated she went to do a med pass and heard a noise coming from the activity table and saw	A 025		

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A 025	Continued From page 3	A 025		

Res#1 with his . . . to her, his . . . tilted . . . and a brown bottle in one and the cap to the bottle in the other. She stated she ran over and took the bottle from him. It was a cement glue bottle. She stated she still did not see the activity staff person at this point. She stated she noticed that 2 ounces were missing from the bottle and resident#1's was full of a substance. She stated he was not . . . at the time. She stated she then called 911 and they called poison control. She stated she did attend a meeting after the incident with management for supervision in Memory care and assuring supplies are supervised always locked up.

In an interview on at 12:45pm with the activity staff D, she stated the resident were doing activity for Mother's Day with paper cut outs and glue. She stated one of the residents at the activity table soiled her pants and needed assistance to go to the bathroom. She stated the remaining residents at the activity table were taken to the lunchroom. She stated since she had to take care of the resident, they were going to finish the activity after lunch, and everything was left on the table. She stated normally there isn't anything left on the table. "We don't usually have an activity that lasts that long but the resident had an accident and was embarrassed so I had to take her to the bathroom." She stated she did not know that cement glue is toxic. She stated poison control was notified and the resident was sent to the emergency room. She stated no staff was around when resident#1 went over to the activity table and therefore the table with the arts and crafts equipment and resident#1 were "unsupervised" at the time.

In an interview on at 1:15pm with the

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A 025	Continued From page 4 administrator, she confirmed the above statements and facts and stated, "they have protocols in place at this time so this would not happen again." Class III	A 025		