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
	AL11964388	A. BUILDING: _____ B. WING _____	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALMETTO LANDING	1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708

(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 Investigations #2022008283 and #2022010450 and a Generator Monitoring were conducted on . Palmetto Landing 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		

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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 observations, record reviews, and interviews, the facility failed to provide adequate supervision and provide care and services appropriate to meet the needs of residents by failing to ensure safety through proactive measures to minimize the potential for and injuries for 1 of 4 sampled residents (#5), and failed to notify the responsible party and a health care provider when 1 of 4 sampled residents alleged a and was sent to the hospital (#7). Findings: 1. Resident #5's record revealed a facility admission date of . An undated 1823	A 025		

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A 025	Continued From page 2 health assessment form (1823) indicated the resident's diagnoses were 's , , , and . The form indicated the resident was a risk. An 1823, dated , indicated the resident required precautions. A facility assessment, dated , indicated the resident's risk for was moderate. A facility note, dated at 11:25 AM, indicated the resident was seen lying on the floor next to her bed. She was unable to say what occurred. The resident continued to walk but with some difficulty. She complained of right , upon performing range of motion. Her family was notified and decided to transport the resident to the hospital themselves. A doctor was also notified. A facility note, dated at 2:15 PM, indicated the resident returned to the facility. A facility note, dated at 10:04 AM, indicated the resident was admitted to the hospital with a diagnoses of a , and a thrombus. A facility note, dated at 6:20 PM, indicated the resident returned from the hospital with a rolling walker. She was alert to self but . A facility note, dated at 8:40 PM, indicated the Memory Care Director saw the resident walking out of the dining room without her walker, lost her balance, then onto the right side of her . She sustained an on her , and two cuts on her forehead. 911 was called and the resident was transported to	A 025		

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A 025	Continued From page 3 the hospital. A facility note, dated at 9:15 AM, indicated the resident returned to the facility ambulating with a walker. She had a golf ball sized hematoma on the right side of her forehead and an on her right . She required assistance with ADLs and transferring. A facility note, dated at 6:22 PM, indicated the resident was seen on her on the TV room floor after she was put to bed around 5 AM. She sustained a on both her left and right elbows. First aid was applied, and notification was made to the family and the doctor. A facility note, dated at 1:27 PM, indicated the resident was moved from to an apartment closer to the nurses' station for monitoring. A facility note, dated at 11:27 AM, indicated the resident was seen getting up from a chair then walk away very fast without her walker. She then lost her balance and . 911 was called and she was transported to the hospital. A facility note, dated at 5 A.M., indicated the resident returned from the hospital. She had a hematoma on both her forehead and right cheek and her upper , was . On at 10:24 AM, the Memory Care Director said that she believed resident #5's were because of the facility not having enough staff to watch the resident. The Director said the resident walked around the unit and to prevent , the director followed the resident around and tried to closely watch her.	A 025		

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A 025	Continued From page 4 On at 12:20 PM, caregiver A said she tried to provide one-on-one supervision for resident #5 and took the resident wherever she went. On at 3:05 PM, Caregiver C said to prevent resident #5 from falling, she put the resident in the common area and sat with her. On at 3:15 PM, the Memory Care Director said she instructed the staff to make sure resident #5 had her walker with her because she oftentimes forgot to use it. She herself followed behind the resident and moved the resident's room closer to the common areas. On at 4:16 PM, Caregiver E said to prevent resident #5 from falling, she always walked with the resident and said the resident did not always use her walker. 2. Resident #7's record revealed a facility admission date of . An 1823, dated , indicated the resident's diagnoses were Displaced left , , , , and . The 1823 indicated that she was alert and oriented only to self. A facility note, dated at 6:45 AM and written by the Regional Director, who was the Administrator at that time, indicated that a medication technician reported that the resident complained of left and was sent to the hospital. A facility note, dated at 12:36 PM, indicated the resident was being sent to the facility after being treated in the emergency room	A 025		

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A 025	Continued From page 5 for a , ( ) and that an , of her , was unremarkable. Hospital discharge instructions, dated , indicated the resident was seen for , . Educational materials on prevention, , and , and were included. The resident's medical record did not contain documentation that the resident's responsible party and the health care provider were notified when the resident was sent to the hospital. On at 3:15 PM, the Memory Care Director said that on resident #7 complained of , , and when the director asked the resident what happened, the resident said she while putting clothes into her roommate's closet. The director said staff did not witness the resident and said she informed Nurse G of the resident's complaint of , and alleged . The Director said she did not document the incident in the resident's record because she did not have access to the electronic charting. The Director said that she did not know the resident was sent to the hospital until she was on the day of the survey. On at 4:39 P.M., the Regional Director said that she was made aware of the resident's alleged only when she received an email from the resident's family on . The Regional Director said that she did not notify the resident's family and the doctor when the resident was sent to the hospital. On at 6 PM, Nurse G said that the Memory Care Director did not inform her of the resident's , , and alleged until , at which time the resident had already been sent	A 025		

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A 025	Continued From page 6 to the hospital. Class II	A 025		
A 028 SS=D	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the activities of daily living (ADLs) needs were met for 3 of 8 sampled residents who were not given their scheduled shower (#1, #7 & #8). Findings: Review of the facility's resident shower list revealed that residents #1, #7 and #8 were all scheduled to receive a shower every Friday during the 2 PM to 10 PM shift. On . . . . at 10:24 AM, the Memory Care Director said that she worked as a caregiver on Friday . . . . . from 2 PM until 10 PM, and that residents #1, #7, and #8 did not receive their scheduled shower because there was not enough staff working on that shift to give them. She said the shower schedule was not adjusted to ensure the showers were given at another time. On at 1:52 PM, the Activities Director said he worked on . . . . . from 5 PM until 7 PM. He	A 028		

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A 028	Continued From page 7 said he did not give any showers while he was there because he was on the medication cart passing medications. He then said he did help with dinner and with putting residents to bed. On at 3:49 PM, caregiver D said he worked on ..... from 7 PM until 7 AM. He said that he did not give any of the three residents their shower because when he arrived at 7 PM, all the residents were in bed. On at 5:17 PM, a telephone interview was conducted with the Administrator, who said that no one told her the residents were unable to receive a shower on ..... She said that despite what the Memory Care Director reported about a lack of adequate staffing, there was enough staff working to have been able to give the showers. On ..... at 5:35 PM, the Business Office Manager said she worked on from 2 PM until 5 PM and that she did not give any showers. Class III	A 028		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents	A 152		

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A 152	Continued From page 8 must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [illegible] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be [illegible] This Statute or Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain a clean environment free from stained and worn carpets for 1 of 4 sampled residents (#7). Findings: On [illegible] at 12:10 PM, stains were seen throughout resident #7's room. In addition, the carpet at the entrance to the room was worn.	A 152		

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A 152	Continued From page 9 On . . . . . at 3:10 PM, the maintenance director confirmed the findings and said the carpet was cleaned approximately two months prior. On . . . . . at 4:39 PM, the regional director said that she herself cleaned the resident's carpet in . . . . . Class III	A 152		