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
	AL11964204	A. BUILDING: _____ B. WING _____	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD PLACE	2680 CROTON ROAD MELBOURNE, FL 32935

(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 for #2022009008 and #2022012507 was conducted at Greenwood Assisted living on and . Deficiencies were identified at the time of the survey.	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 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	A 025		

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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 interview, the facility failed to provide care and services appropriate to meet the needs of residents by failing to assess appropriately for change in condition for 1 of 2 residents sampled (#4). Findings: On . . . . . a review of the admission and discharge log revealed resident #4 was discharged on . . . . . to the hospital for change in level of . . On a review of resident #4 record revealed	A 025		

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A 025	Continued From page 2 he was admitted on . . . . . He was discharged on . His record contained a Resident Health Assessment Form (1823) dated . Review of the 1823 revealed he was oriented to person and place. He had a history of . He ambulated with a walker. His diagnoses included and , hypertrophy. Further review of resident's record did not reveal any facility notes for . . . . . . On . . . . . at 12:45 During an interview with the administrator, she said resident #4 was discharged to the hospital for a possible . . . . . She said his grandson picked him up and took him to the hospital. She said she saw him in the lobby when she was leaving that afternoon around 5:30-6pm. On . . . . . at 11am during an interview with the administrator, she confirmed resident #4 on . . . . . and had . . . . . She confirmed there was no documentation of an assessment for injury. She confirmed there was no documentation of 911 being contacted or paperwork being provided to the family or first responders. On at 12pm a review of the facility's' incident report dated . . . . . at 5pm was conducted. The report revealed resident #4 was found lying on his right side almost in a . . . position. The report was signed by staff E. On at 1:50pm in an interview with staff E, she said she worked the second shift on . . . . . She said resident #4 that day about 5pm. He slipped off the bed. She and Staff A picked him up. She said after the , resident complained of	A 025		

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A 025	Continued From page 3 . . / . . . and started limping. She said after the he tried to walk to the elevator to go upstairs but was not able too. His balance was not good. She said his speech was Ok, but his balance was off. She said Staff A was the staff that would have called the family, and ambulance, and provide transfer paperwork. She said she never saw fire rescue paramedics in the building. Family came and took him to the hospital because the non-emergency ambulance was going to take 2 hours. Class III	A 025		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. . . . . ; 2. or , damage; 3. Permanent . . . . . ;	A 165		

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A 165	Continued From page 4 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) [illegible], neglect, or [illegible] must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially	A 165		

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A 165	Continued From page 5 involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to submit an adverse incident report for 1 of 2 sampled residents. (#3). Findings: On .. . . . review of resident #3 record revealed he was admitted on and discharged on to the hospital. His record contained a Resident Health Assessment form (1823) dated	A 165		

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A 165	Continued From page 6 . . . . . Review of the 1823 found his diagnoses include , , , , , and . . . . . . Review of facility notes revealed resident #3 was found on the floor at 8:14 am on . The facility note documented his left arm was . . . and and he was sent out 911. Further review of resident #3 record revealed hospital notes including , done on with a diagnosis of . . . . . hematoma left upper arm. No acute . Could not exclude a tear to the bicep . . . . . Resident #3 was admitted to the hospital On a review of the facility's adverse incidents revealed none were submitted for resident #3. On at 12:45pm during an interview with the administrator, she confirmed resident #3 went to the hospital after a on . She said she did not do an adverse incident because he did not have a . On the facility's policy for reporting adverse incidents was reviewed. The policy identified reportable events as an accident, unusual event, or an emergency that results in an injury requiring hospitalization such as or . . . injury. Class III	A 165		