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
	AL11965534	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL CLUB	2751 NE 183 STREET AVENTURA, FL 33160

(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 Survey (#2022017753, #[redacted] #2022015319 and # 2022014171) was conducted at Imperial Club on [redacted], through [redacted]. Deficiencies were identified at the time of the survey.	A 000		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; [redacted], Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida [redacted] Hotline, 1(800)96- [redacted] or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents	A 030		

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A 030	Continued From page 1 and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where	A 030		

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A 030	Continued From page 2 residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from [redacted] and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as	A 030		

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A 030	Continued From page 3 provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with	A 030		

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A 030	Continued From page 4 relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility	A 030		

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A 030	Continued From page 5 must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and . . . . , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that one out of six sampled residents (Resident #4) lived in a safe and decent living environment. Resident #4, who was sleeping on an air mattress in the absence of her furniture and who complained of , , was not provided with assistance. Findings included:	A 030		

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A 030	Continued From page 6 Observation on . . . . . at 9:35 AM revealed Resident #4 in her room with an air mattress on the living room floor and a bed frame in the bedroom with no mattress. During an interview on at 11:51 AM Resident #4 stated "It is just really inconvenient having an air mattress. My is really bothering me since I've been on the air mattress. I don't know if they have the option to loan out a mattress here until mine arrives. I don't know when my mattress is coming." During an interview on at 12:21 pm, The Administrator stated "The facility does not provide any furniture for the residents. Even in instances of , we would still not provide any furniture for the residents. We don't have any extra beds because we don't provide any furniture. I spoke to [Resident #4's] case manager yesterday and she said the mattress was supposed to be delivered yesterday and it is coming today. The case manager said she would put in a call to city furniture and see what's going on, she said she was supposed to be getting a mattress, dining table and a lamp." Class III	A 030		
A 152 SS=F	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,	A 152		

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A 152	Continued From page 7 and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents 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 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 . This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. Findings included:	A 152		

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A 152	Continued From page 8 Observation on [redacted] at 9:08AM revealed a sign on the right side elevator reading "Please use other elevator." During an interview on [redacted] at 9:18AM The Executive Director stated "The elevator has been out since [redacted]. Only 1 elevator is working. We have had two companies come out to fix the elevators." Review of the contractor log book revealed an elevator contractor came to the facility on [redacted], and [redacted]. On [redacted] at 11:05AM Resident #5 stated "The elevator is slow." On [redacted] at 11:43AM Resident #6 stated "Sometimes I have to wait a bit for the elevator." On [redacted] at 11:51AM Resident #4 stated "The elevator is the problem here, it takes long" During an interview on [redacted] at 9:40AM, The Administrator stated "The [Assisted living facility] residents get their food delivered to the room. They don't really have the problem of waiting for the elevator for meals. That's the independent living residents who are complaining about the elevators. Not the [Assisted living facility] residents" Observation on [redacted] at revealed a sign on the right side elevator reading "Please use other elevator." During an interview on [redacted] at 10:30AM, The	A 152		

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A 152	Continued From page 9 Administrator stated "The Assisted Living Facility residents are on floors 3, 4, and 5." Review of the contractor log book revealed an elevator contractor came to the facility on . . . . , , , , , , ... , ... During an interview on . . at 10:23AM, Resident #4 stated "Both of the elevators have been out for the past couple of weeks. They only fixed it just yesterday. It was terrible, I just watched tv in my room. I had to walk down the steps, it is very dangerous and I had no other way. They told us that we could not go downstairs and they would bring food up to us." Review of Resident #4's health assessment completed on . . . . . revealed the resident was independent with all activities of daily living. During an interview on at 11:02AM Resident #7 stated "Every other day the other elevator is out of order. The other elevator has been out for over 5 months, the one on the right. Now, the elevator that was working is out all the time. When both elevators are broken, they send the food up. Their response is 'You have to understand' . Sometimes the elevator is working then you go downstairs and the elevator is out again. I had to take the stairs and I use a walker, my private duty aide had to carry my walker. I was in so much , . . after. My doctor prescribed me , medications. I have spoken to [The Administrator] about it many times, my grandson has called three times and they always say they are in a meeting. They never get . . . to him and he calls every week. My ,, are killing me from walking, both elevators were out just yesterday. "	A 152		

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A 152	Continued From page 10 Review of Resident #7's health assessment completed on revealed the resident required assistance with ambulation, bathing, , toileting, transferring and grooming. Review of Resident #7's record revealed a prescription from her physician completed on for 50 mg take 1 tab 2x daily with food. According to Mayo Clinic, is used to reduce , , ( ), and , stiffness from . During an interview on at 11:29AM, Resident #1 stated "Yesterday the elevators were not working. When that happens, I can't go downstairs I just hope and wait for them to bring the food up. When the elevator is not working, I get no activities. They say 'We ordered a part and its in New York.' Review of Resident #1's health assessment completed on revealed the resident was independent eating and grooming, and required assistance with bathing and supervision with ambulation, , toileting, and transferring. During an interview on at 11:47AM The Executive Director (Staff G), stated "We voluntarily chose to shut down the elevator because it was not working perfectly. So we called Oracle to come out to work on the elevator. It wasn't that Elevator 1 was not functioning, it was working on request. We informed the residents over the PA system that we were going to shut off the elevators. The elevator was working on request, we tell them that if they need to use it they can call the front desk and we will turn it on."	A 152		

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A 152	Continued From page 11 During an interview on at 10:48AM, The Administrator stated "The elevator is working. One elevator has been down for 5 months, but there is no regulation for there to be 2 working elevators." During an interview on at 12:30PM, The City of Aventura Code Compliance Officer stated "I became aware of the issues involving the elevators at the [facility] last year. There are two elevators in use. One elevator is routinely problematic and the other needs servicing less so. I fielded several calls regarding the concern about the condition of these elevators and have referred all complaints to Miami-Dade County Elevator Enforcement. " During an interview on at 2:30PM, The County Elevator Enforcement Chief Elevator Inspector stated "We have received numerous complaints about the elevators.When we saw the elevator was running on independent instead of on automatic, we informed the facility staff that this was not allowed, and they can incur a fine of up to $1000 a day if we return and find the elevator running on independent again. The reason they would receive such a fine is because it inhibits safety for the building because there is no accessibility to the other floors. During an interview on at 1:44PM, The [] Elevator Service Manager stated, "They have one of the units running in perfect condition, the second is shut down and waiting on parts, it was ordered and they are on order. There is no estimate date on when it will be delivered. We started getting calls last week about the elevator being down and we sent a mechanic and we fixed it. The elevator was not working when they called	A 152		

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A 152	Continued From page 12 us. We fixed the elevator last Thursday. We were working on it from Wednesday to Sunday." Review of facility records revealed 6 residents required assistance with ambulation, 9 residents required assistance with transferring, 8 residents required supervision with ambulation, 2 residents required supervision with transferring. During an interview on at 11:05AM when asked what the facility was doing to safeguard residents when the elevators were . The Administrator stated "Both the elevators are not broken. One is still working. The residents are still able to use it. We have staff ride the elevators to help decrease the time it takes to get to each floor. We have staff bring the meals to the residents. The residents are still able to go to their doctor because one of the elevators is still working." Class II	A 152		
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	A 165		

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A 165	Continued From page 13 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. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 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.	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965534	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL CLUB	2751 NE 183 STREET AVENTURA, FL 33160

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A 165	Continued From page 14 (6) [redacted], neglect, or [redacted] 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 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	A 165		

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A 165	Continued From page 15 failed to submit an adverse incident report with the Agency for Health Care Administration (AHCA) within one business day for one out of six sampled residents (Resident #1). Findings include: A review of Resident #1's progress notes dated [illegible] showed, "complained of severe [illegible] this morning. [Resident #1] cannot even stand without writhing in [illegible]. Resident #1's] son still has not taken the resident to be checked out at a clinic or doctor's office. 911 was called at approximately 9:32 AM. Paramedics arrived at approximately 9:43 AM and left with [Resident #1] for [hospital] at approximately 9:57 AM." A review of Resident #1's hospital record dated [illegible] showed a 'History of Present Illness' stating ", male presents to the emergency department for [illegible]. He was found to have an L1 [illegible]. The patient had intermittent low [illegible] for the past few weeks, but it significantly worsened over the past few days. [illegible] mainly over the [illegible] area, exacerbated by movement and slightly relieved by laying down. He reports recurrent mechanical [illegible] due to loss of balance. The patient stated that one day prior, he had a mechanical [illegible]. He states he [illegible] on his glutes." A review of the agency's adverse incident report history showed the facility reported Resident #1's [illegible] and injury on [illegible]. During an interview on [illegible] at 1:20 PM, when asked why there was a delay in the reporting of Resident #1's hospitalization, the Administrator stated, "The son told me but I couldn't confirm with the hospital that it was an	A 165		

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A 165	Continued From page 16 actual . . . . . On . . . . . at 12:17 PM, the Administrator further stated, "It was only later they sent something saying he had a . . . . . The day I got it, I notified AHCA (Agency for Health Care Administration)." Class III	A 165		

Agency for Health Care Administration

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A 025 SS=H	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 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	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 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 interview and record review, the facility failed to provide adequate supervision as appropriate for each resident to ensure awareness of the general health, safety, and physical and emotional well-being of three out of six sampled residents (Residents #1, #2 and #3). Resident #1 sustained a [redacted], Resident #2 sustained a left [redacted], and Resident #3 was diagnosed with a large [redacted] hematoma with severe signs of [redacted] and [redacted] after sustaining a [redacted]. Findings include: 1) A review of progress notes dated [redacted] showed, "[Resident #1] complained of [redacted] in both [redacted] this afternoon. When asked where the [redacted] came from, [Resident #1] stated that he onto his butt while walking towards his couch two days ago. [Resident #1] does not know what caused the [redacted]. The Director of Nursing (DON) has been informed and contacted [Resident #1's]	A 025		

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A 025	Continued From page 2 primary care physician to order a mobile . DON to notify the resident's son as well. given in the meantime." A review of Resident #1's record, however, showed no documentation of any interventions after the resident on . Further review showed no documentation that the physician was contacted for recommendations to prevent the reoccurrence of . On at 12:50 PM, when asked what preventive measures were put into place after Resident #1's first , the Administrator stated, "We educated him on using his walker, and we spoke to his son so he could speak to his father. He doesn't like to use the walker in his apartment." A review of Resident #1's health assessment dated showed medical history and diagnoses of 's , , and . The resident was independent with ambulation, eating, toileting, and transferring and needed supervision with bathing, , grooming and self-administration of medication. The health assessment indicated that Resident #1 had universal precautions. A review of Resident #1's progress notes dated showed, "complained of severe / this morning. [Resident #1] cannot even stand without writhing in . Resident #1's] son still has not taken the resident to be checked out at a clinic or doctor's office. 911 was called at approximately 9:32 AM. Paramedics arrived at approximately 9:43 AM and left with [Resident #1] for [hospital] at approximately 9:57 AM."	A 025		

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A 025	Continued From page 3 A review of Resident #1's hospital record dated [illegible] showed a 'History of Present Illness' stating ", male presents to the emergency department for [illegible]. He was found to have an L1 [illegible]. The patient had intermittent low [illegible] for the past few weeks but gotten significantly worse over the past few days. [illegible] mainly over the [illegible] area, exacerbated by movement and slightly relieved by laying down. He reports recurrent mechanical [illegible] due to loss of balance. The patient stated that one day prior, he had a mechanical [illegible]. He states he [illegible] on his glutes." A review of the adverse incident report filed on [illegible] showed on [illegible] at 9:05 AM, Staff C, Certified Nursing Assistant (CNA), notified Staff D, Licensed Practical Nurse (LPN), that she found Resident #1 lying down on his right side complaining of a lot of [illegible] to the lower [illegible] area and wanting to go to the hospital. Staff D then checked on the resident and was told he was not feeling well. 911 was called, and the resident was transferred to the hospital, where he was diagnosed with a [illegible]. Resident#1's son informed the facility that his father had an unwitnessed [illegible] in his apartment while ambulating without his walker. During an interview on [illegible] at 12:52 PM, when asked about Resident #1's [illegible], the Administrator stated, "That was unwitnessed. Only when [Staff C] found him when she was doing rounds. He was lying on his side on the couch. He said he was having [illegible]. Then [Staff D] went to check on him. At that time, he asked to go to the hospital." In an interview with Staff C on [illegible] at 1:05	A 025		

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A 025	Continued From page 4 PM, she stated, "I did not see the resident . I was doing my rounds, we do them every two hours, and I saw him lying on the couch. He told me that his , was hurting him. I went to get the nurse." When asked about the type of assistance Resident #1 needed, she stated, "I drop off his breakfast in the morning. He bathes, dresses and goes to the bathroom himself." On at 12:54 PM, when asked what precautions would be put in place to prevent Resident #1 from continuing to , the Administrator stated, "The same thing. We will educate him and continue to do our two-hour rounding." 2) A review of Resident #2's records showed the resident had more than three in . A review of Resident#2's health assessment dated showed medical history and diagnoses of , , , and dyslipidemia. The resident needed assistance with ambulation, eating, self-care, toileting, transferring and self-administration of medication and was in total care with bathing. The health assessment indicated that Resident #2 had precautions. A review of progress notes dated showed, "staff reported that [Resident #2] slipped while getting out of bed this morning and bumped her arm on, which caused her to develop a on her left . cleansed, , dried, and covered with , gauze and a gauze bandage." A review of progress notes dated showed Resident #2 in her apartment early in the morning. No injuries were noted.	A 025		

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A 025	Continued From page 5 A review of Resident #2's progress notes dated ..... showed, "received a phone call from the front desk at approximately 7:49 AM that [Resident #2] and hurt her right a few minutes ago. [Resident #2] does not know what caused the , and there were no witnesses around at the time of the incident. The on [Resident#2's] right has been cleansed, , dried, and covered in and a bandage. [Resident #2] has and injured herself several times recently. The DON has been made aware. DON notified me she spoke to her daughter and suggested increased private duty aide (PDA) hours. The daughter advised DON she's unable to afford additional PDA hours." A review of progress notes dated ..... showed, "nursing staff reported that [Resident #2] again early this morning. There was no one around when [Resident #2] . The resident pressed her pendant, and when staff arrived at her apartment, they observed her sitting on the floor of her bedroom. No injuries were noted at the time. A call was placed to her daughter that the mom would need a 24-hour PDA until the resident appeared better. The daughter stated she is unable to afford this at this time." A review of progress notes dated ..... showed, "At approximately 1:11 AM, [Resident #2] pressed her pendant. The 5th-floor medication technician, [Staff E], immediately went to assist. Upon entering the resident's apartment, [Resident #2] was observed lying on the bedroom floor on her left side. [Resident #2] told [Staff E] that she was coming from the bathroom and slipped and . [Resident #2] complained of severe , in her left and was unable to	A 025		

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A 025	Continued From page 6 stand. 911 was called at approximately 1:14 AM and transported her to [hospital]. DON is aware. Family is aware as well." A review of Resident #2's hospital record dated showed a 'History of Present Illness' stating ", female with a history of recurrent presents to the emergency department via emergency medical services ( ) for evaluation of left following earlier tonight. Per aide witnessed the patient landing on her left , without loss of . Per the patient's daughter at the bedside, the patient told her she tripped and earlier in the night, got up and went to bed before calling 911 for worsening , . The patient now does not recall falling. Has recurrent lately and daughter noticed declining energy over the past several months." The resident was diagnosed with a left . In an interview on at 1:08 PM, Staff E, Medication Technician, stated, "She has more than once. The on my shift happened on Thursday, , overnight, around 1 AM. I just left her room and came downstairs. She used to get up on her own even when you tell not to. I think she had 's. Five minutes later, she pressed the button. I found her on the floor." When asked about the type of care Resident #2 needed, Staff E stated, "[hospice] would come to bathe her, and her aide would come in the morning to do everything else. We would check her , and give her medication. At night every two hours, we check and take her to the bathroom." On at 12:31 PM, when asked what preventive measures were put into place for Resident #2's, the Administrator stated, "She did	A 025		

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A 025	Continued From page 7 not receive , , ... , , . The daughter got an aide. She needed someone one-on-one with her because we are an ALF. I told the daughter that her mother wouldn't be able to stay without an aide. The aide would come for nine hours from 8 AM -6 PM every day. Then her daughter was saying she couldn't afford the rent and an aide; when she the last time, the daughter took her to the hospital and said she wasn't bringing her ." A review of Resident #2's monthly status summary, last completed on . . . . . , indicated no third-party services such as , , . . . , , or any comments in the section about whether changes occurred or decline in status and what steps were taken. A review of Resident #2's record showed no documentation of any interventions or investigation into the resident's prior . . other than asking the resident how she . There was no documentation that the physician was contacted for recommendations to prevent the reoccurrence of . . . On . . . . . at 12:34 PM, when asked if the facility's contact Resident #2's physician about her recurrent . ., the Administrator stated, "We would call the doctor. There would be no response. We suggested hospice to her daughter, and she started receiving that shortly after. Hospice ran tests, and no issues were found." 3) A review of Resident #3's progress notes dated . . . . . showed, "Pressed her pendant at approximately 3:01 PM. Assisted Living Director, [Staff B] went to assist the resident and observed her prone on the floor of her bathroom. 911 was	A 025		

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A 025	Continued From page 8 called at approximately 3:05 PM. A scant amount of was noted near the resident's . [Resident #3] explained that she was trying to stand from the toilet and on the floor. Paramedics arrived at approximately 3:35 PM. Upon flipping [Resident #3] onto her , the paramedics observed that the resident's was heavily with moderate as well. Paramedics left with [Resident #3] at approximately 3:40 PM for [hospital]." A review of Resident #3's hospital record dated showed a 'History of Present Illness' stating, "patient presents emergency room via (emergency medical services) after syncopal episode and causing herself bone . The patient had an unwitnessed while sitting on the bathroom toilet at 4 AM in the morning. She states she was trying to stand up to pick something from the shelf and felt , afterwards, causing her to slip and . She down to the floor, landing on her and got stuck in the with a heavy metal piece. States she grabbed the shelf, which also on her . The patient has a large hematoma with severe signs of and subconjunctival " A review of Resident #3's progress notes showed that the resident had a prior in the bathroom on , where she was also transferred to the hospital. A review of Resident #3's health assessment dated showed medical history and diagnoses of , , , and surgery. The resident needed supervision with eating and assistance with ambulation, bathing, grooming, toileting, transferring and self-administration of medication. The health	A 025		

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A 025	Continued From page 9 assessment indicated that Resident #3 had precautions. During an interview with Resident #3's private duty aide on /22022 at 11:10 AM, she stated, "I work as a PDA for six days of the week, from PM or PM. The resident is alone on Sundays. She several times while here, but she did not just once. Her last was in , ; she went to [hospital]. She always with injury. She is always alone when happen. It's never when I am with her." On at 12:26 PM, when asked what preventive measures were put into place after Resident #3's initial , the Administrator stated, "Prior to this, our measures were providing more checks on her rather than the more hours. They said it was due to her valves that is why she was falling." A review of Resident #3's monthly status summary completed from to showed no comments in the section about whether changes occurred or declined in status and what steps were taken. A review of Resident #3's record showed no documentation of any interventions or investigation into the resident's prior . There was no documentation that the physician was contacted for recommendations to prevent the reoccurrence of . On at 12:27 PM, when asked if the facility had contacted Resident #3's physician about her recurrent , the Administrator stated, "We spoke to the doctor, and he did not realize that it was her valve causing the ."	A 025		

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	AL11965534	A. BUILDING: _____ B. WING _____	12/09/2022

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A 025	Continued From page 10 In an interview on . . . . . at 12:25 PM, when asked what measures are in place to prevent Resident #3 from failing, the Administrator stated, "We contacted her family to provide more hours with her private aide. We checked on her every hour, but we felt she needed more. The PDA (Private Duty Aide) is here from 9 AM. The son just recently increased the hours since last month." A review of the facility's records showed no documentation of a prevention policy. On at 1:16 PM, when asked whether the facility had a prevention policy, the Administrator stated, "No, we don't." On at 1:00 PM, when asked whether the facility has the primary care physician reassess the residents after they have to determine if there was a change of condition, the Administrator stated, "No, but I evaluated [Resident #1] at rehab to see if he still met the criteria." Class II	A 025		
A 160 SS=D	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper	A 160		

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A 160	Continued From page 11 format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a [illegible]; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C.	A 160		

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A 160	Continued From page 12 (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.	A 160		

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A 160	Continued From page 13 This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain an up-to-date admission/discharge log. Findings include: On ..... at 9:49 AM, when asked if Resident #2 still resided at the facility, the Administrator said, "She is discharged." When asked the reason for the discharge, the Administrator stated, "She just didn't want to be here." A review of the admission/discharge log showed Resident #2 was admitted on ..... and discharged on . There was no documentation of the reason for Resident #2's discharge and the facility or home address to which the resident was discharged. During an interview on ..... at 12:31 PM, when asked about the missing details concerning Resident #2's discharge, the Administrator stated, "The daughter didn't tell us where she was going. She needed a higher level of care. She was total care. She had a and went to the hospital." Class III	A 160		
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	A 165		

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A 165	Continued From page 14 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 ; 4. or 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.	A 165		

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A 165	Continued From page 15 (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) , neglect, or , 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 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	A 165		

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A 165	Continued From page 16 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 with the Agency for Health Care Administration (AHCA) within one business day for one out of six sampled residents (Resident #1). Findings include: A review of Resident #1's progress notes dated [redacted] showed, "complained of severe [redacted] this morning. [Resident #1] cannot even stand without writhing in [redacted]. Resident #1's] son still has not taken the resident to be checked out at a clinic or doctor's office. 911 was called at approximately 9:32 AM. Paramedics arrived at approximately 9:43 AM and left with [Resident #1] for [hospital] at approximately 9:57 AM." A review of Resident #1's hospital record dated [redacted] showed a 'History of Present Illness' stating ", male presents to the emergency department for [redacted]. He was found to have an L1 [redacted]. The patient had intermittent low [redacted] for the past few weeks, but it significantly worsened over the past few days. [redacted] mainly over the [redacted] area, exacerbated by movement and slightly relieved by laying down. He reports recurrent mechanical [redacted] due to loss of balance. The patient stated that one day prior, he had a mechanical [redacted]. He states he [redacted] on his glutes." A review of the agency's adverse database	A 165		

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A 165	Continued From page 17 showed the facility reported Resident #1's and injury on . During an interview on at 1:20 PM, when asked why there was a delay in the reporting of Resident #1's hospitalization, the Administrator stated, "The son told me but I couldn't confirm with the hospital that it was an actual . On at 12:17 PM, the Administrator further stated, "It was only later they sent something saying he had a . The day I got it, I notified AHCA." Class III	A 165		