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
	AL11967569	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF TITUSVILLE	497 N WASHINGTON AVE TITUSVILLE, FL 32796

(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 #2022013473 was conducted on [redacted] Addington Place of Titusville had a deficiency found 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 [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 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		

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 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 interview and record review, the facility failed to provide appropriate supervision, causing a resident to sustain a with injuries (#1). Findings: Resident #1's record and health assessment dated , confirmed an admission date of . Medical history revealed a , region, solitary , nodule, high , . Nursing care for , prep and assistance with medications were ordered.	A 025		

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A 025	Continued From page 2 Resident #1's facility notes revealed the following unwitnessed : . . . . . at 7:35 AM - The resident was found lying on her in her room. She had left , and stated she hit her . A on her forehead was noted. The resident states she wanted to go to the hospital, and was sent out by ambulance via emergency medical services. . . . . . - The resident returned from the hospital. She had a left , wore a left arm sling, and had 2 steri strips to the on her forehead. at 3:16 PM - The resident was on an outing with staff and other residents when she at the store. Staff went to get a shopping cart and when staff returned, they found the resident on her in the wheelchair ramp area on the sidewalk. The nurse came to the scene. When the nurse and staff assisted the resident in getting up, she was not able to put on her right . The resident stated she wanted to go the hospital and 911 was called. The resident was admitted into hospital. at 7:04 PM - The resident's hospital examination indicated a right , ... at 11:13 AM - The resident returned to the facility from the hospital. She needed assistance with getting up and down from a sitting position and walking. at 2:47 PM - The resident was found on the floor around 7:10 AM. She first stated she hit her and wanted to go to the hospital. When emergency services came, she refused to go to the hospital. There was no documentation	A 025		

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A 025	Continued From page 3 of a new individual support plan or interventions put into place for resident #1. On at 9:30 AM, staff A, the activity staff during the incident on the outing on , stated the day of the incident she took 5 residents to the convenience store. She stated normally they have 2 staff go on an outing but since there were only 5 residents she went alone. She stated she told the residents to remain seated while she leaves the bus for a minute to get shopping carts for them. She stated she left the bus door open by mistake. She stated resident #1 is independent and took it upon herself to leave the bus and she when taking the steps. She stated the resident was laughing and stated she was not in , and not to call 911. She stated she immediately called the nurse at the facility, who came to the store within minutes to assess the resident. When the nurse tried to help her stand up, the resident said she was in , and the nurse called 911. She stated she went to the hospital and had a . She stated resident #1 did not need assistance with activities daily living before this incident. She only had assistance with medications and was very mobile. She confirmed she was not aware of any interventions put into place for resident #1 prior or after the incident. On at 11:30 AM, Staff B stated resident #1 has had multiple unwitnessed but was unaware of any interventions put in place for her. She explained that resident #1 wanted to be independent. On at 12 PM, Staff C stated resident #1 was very independent and did not need assistance with activities of daily living until the last . Staff C stated resident #1 liked to do	A 025		

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A 025	Continued From page 4 things on her own. The resident refused to call for assistance. She further stated the resident was [illegible] aware and would just do her "own thing". Staff C was not aware of any interventions that were in place for resident #1 due to her [illegible]. On [illegible] at 1 PM, the Administrator confirmed the findings and stated since the incident they implemented a policy that the bus door remain closed until staff is ready to take the residents off the bus. He stated there was no policy like that at the time. The facility's " Policy" revealed that when a resident has a or continues to have , the Individual Support Plan (ISP) will be updated after each with interventions. The Wellness Director will reevaluate every 6 months. The resident's record did not contain documentation of any interventions put into place after the . Class II	A 025		