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 _____	01/04/2023

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 Investigation #2022014979 was conducted on [redacted]. Palmetto Landing had a deficiency 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 [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 resident diets in accordance with Rule 59A-36.012, F.A.C.	A 025		

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A 025	Continued From page 1	A 025		

(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 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 3 of 4 sampled residents who experienced . . (#1, #5 & #6).

Findings:

1. Resident #1's record revealed a facility admission date of . A 1823 health assessment form, dated . . . . . , indicated the resident's diagnoses were major , ... severe without , , . . . features, and (AD). The resident was

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A 025	Continued From page 2 independent with ambulation and transferring. An [redacted] 1823 form indicated the resident's diagnoses were AD, [redacted] D deficiency, [redacted] (HLD), [redacted] ( ), [redacted] risk, and [redacted]. She had [redacted] precautions, an unsteady gait, uses walker, was forgetful due to [redacted], and needed supervision with ambulation and transferring. A [redacted] health care provider's visit note indicated the resident ambulated slowly with a walker with an unsteady gait. A [redacted], [redacted] and [redacted] facility risk assessment identified the resident as a high [redacted] risk. On [redacted] 7:51 PM, the resident was found on the floor in the hallway next to her room door. She said she was opening her room door when she lost her balance and [redacted]. No injuries were noted. She was reminded to call for assistance for safety, and verbalized understanding. On [redacted] 4:48 PM, the resident was encouraged to request assistance as needed. On [redacted] 7:32 PM, the resident ambulated throughout the community. She was educated on use of a pendant to call for assistance. On [redacted] 5:03 PM, the resident was transferred to the memory care unit due to exit seeking behavior. On [redacted] 4:37 PM, the resident was found on the floor in the activity room. She said she was trying to get something from the refrigerator and	A 025		

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A 025	Continued From page 3 lost her balance. Her walker was far away from her at the time of . She complained of left , and per another resident, she hit her . She was observed between the refrigerator and the popcorn machine. 911 was called and she was transferred to the hospital. She returned the same day with a sling to her arm. A facility report indicated that at approximately 4:30 PM, "This resident and hit her , witnessed by another resident. The Activity Coordinator was not in the room but returned immediately to find the resident on the floor between the refrigerator and popcorn machine. When asked what happened, the resident stated, "I was trying to get something from the refrigerator and lost my balance." The witness stated resident #1 hit her . A nurse was called to assess the resident. The resident used a walker for ambulation and the nurse noticed the walker was far away from the resident. The resident complained of left , and 911 was called at approximately 4:35 PM. The resident transported to the hospital. Her primary care provider and guardian were notified. Facility analysis of the incident reflected that the resident normally ambulates with a walker supervised. She received supervisory assistance with care, was independent with eating, needed assistance with bathing and medication management. On at approximately 4:30 PM, the resident witness stated she observed resident #1 walking into activity room, and then saw the resident over and hit her . When asked what happened, resident #1 stated, "I was trying to get something from the refrigerator and lost my balance." A nurse assessed the resident. According to the facility, the reason for the was unknown, but appeared to be a loss of	A 025		

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A 025	Continued From page 4 balance due to unsteady gait and not using her walker properly. The facility's corrective action to remind the resident to use her walker, provide resident assistance when needed for ambulation, and to reeducate staff on the "Falling Star" program. A hospital history and physical indicated the resident presented to the emergency department following a and sustained a left On ..... at 2:22 PM, resident #1 was sent to the hospital per guardian request. The resident left the facility with a sling on left her arm. Her family wanted the hospital to send her to a rehabilitation hospital. On at 2:20 PM, the Activities Director said when resident #1 on at approximately 4:30 PM, he was leading a bingo activity in the assisted living activity room. He said that although resident #1 lived in memory care at the time, her assisted living friends asked him to bring her to the activity. He said he left the room to get a glass of water for one of the residents from the kitchen, which was approximately 10 from the activity room when he heard "a commotion" coming from the activity room. He said he left the door open when he left the room and had been gone for approximately 7 seconds before the commotion. He immediately returned to the room and saw resident #1 on the floor near the popcorn machine, which was immediately to the left of the room's entrance. He said the resident complained of , so he told the on-duty nurse, who responded. He said the resident used a walker to ambulate. He said a "star" on the wall next to a resident's door meant the resident was high risk for and that he received training on	A 025		

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A 025	Continued From page 5 the falling star program. 2. Resident #5's record revealed a facility admission date of . An 1823 form, dated , indicated the resident's diagnoses were type 2, , and hypoxic , failure. He used a wheelchair, was alert and oriented to self, had no special precautions, and needed assistance with ambulation and transferring. A 1823 form indicated the resident was alert to self, was able to make needs known and had intermittent forgetfulness. The primary care provider ordered physical and . He needed assistance with activities of daily living (ADLs), ambulation and transferring. An health care provider's note indicated home health was ordered for and unsteady gait. On at 6:13 PM, the resident was seen for a evaluation for transfer training. On at 6:07 PM, the resident was seen for for safety with ADLs and transfers. On , the resident was discharged from . He had reinforcement for prevention strategies and transfer training. On at 1:43 PM, the resident was found by staff lying on his on the floor in the activity room. He stated he was going to the bathroom without asking for assistance and on his . He denied hitting his . No injury was noted. The resident was reminded to call for assistance for safety, and verbalized understanding.	A 025		

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A 025	Continued From page 6 On at 7:18 PM, staff continued to assist him in his wheelchair and supervise him during meals. On , a hospital bed was ordered for safety and positioning. A and assessments indicated the resident was a high risk for . A 1823 indicated that he "requires supervision" under special precautions. Hospice services were ordered. On , hospice services started. On at 6:19 PM, staff heard the resident yell for help. Staff found him on the floor near his bed. He said he was attempting to transfer from the wheelchair to the bed alone. No injuries were seen. On at 2:08 PM, Caregiver B said she knew resident #5 was at risk for so she monitored him when he was in his bed. When asked how often she did that she replied, "We're always going up and down the halls all day and we peek in there." She said when he was not in his room she assisted him from his wheelchair to a couch in the dayroom and kept him involved in activities. On at 4 PM, Caregiver E pointed up to where one of the black circle magnets was on the door frame and said that meant that the resident "needs help with everything". He was asked if the star meant anything, and he said he did not know. He said resident #5 was at risk for so he "checked on him every two hours, watched him,	A 025		

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A 025	Continued From page 7 paid attention to him, made sure he was comfortable and clean." 3. Resident #6's record revealed a facility admission date of . . . . . An 1823 form, dated , indicated the resident's diagnoses included . . . . . , history of . . . , ( ), , and 2 closed . . . . . The resident had frequent episodes of agitation and , was a risk, and needed supervision with ambulation, and transferring. She "Poses risk to self or others and requires 24-hour nursing or , . . , ... care. . . has frequent episodes of agitation/ , . . . has history of . . . and is considered a . . . risk." A . . . . . risk assessment indicated the resident was moderate risk for . A health care provider ordered for , . . 5 milligrams by . . . twice daily. . . . , . ' generic name is , . ` " , is used to prevent serious . . . . clots from forming due to a certain irregular heartbeat (. . . .) or after , / . . replacement surgery. With . . . , part of the does not beat the way it should. This can lead to . . . clots forming, which can travel to other parts of your body (such as the . . or . .) or increase your risk for . In the United States, , is also approved to treat certain types of . . . clots (, ~ , , ... -PE) and to prevent them from forming again." (Retrieved from on webmd.com). On at 2:57 PM, the resident ambulated independently . . . and forth in the hallway. On at 8 PM, staff heard the resident yell for help from her room. Staff found the resident	A 025		

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A 025	Continued From page 8 on the floor by her door. She was unable to give a description of the incident and complained of a . . . . . 911 was called, and she was transported via stretcher to the hospital. A , a facility report indicated that at 8 PM staff "was rounding in our memory care neighborhood and heard someone yell out 'help me'. Med tech (Medication Technician) observed resident laying on floor behind door, preventing it from being opened fully. Med tech noticed . . . and asked resident 'Are you okay, do you have , . . ? Resident responded, 'my . . . hurts. Med tech then asked, 'what happened', resident responded 'I do not know'. Med tech called 911 between 8:05 PM-8:10 PM and then alerted health and wellness director, family, and primary care physician of incident. Per verbal from (hospital) resident had a . . . . . hematoma and needed an MMA (middle meningeal . , embolization) procedure. Resident was checked on around 7:45 PM prior to by med tech. Per med tech, resident was watching TV and did not need anything at that time. Resident has . . . . . and resides in our MC (memory care) neighborhood. Analysis was resident does not remember how she and there was no witness. Upon entry to apartment med tech did see a remote and pillow on floor. However, she was wearing no slip socks and does not use a mobility aid. Corrective action was once resident returns from hospital we will set up , . . . , , continue to encourage nonslip socks and place on our falling stars program." "MMA embolization involves guiding a . . . . . that is inserted into a to the area of the that is supplying . . . . to the . . . . . hematoma. Particles or a special type of glue will be released to stop the . . . . . that is causing the . . . . . hematoma." (Retrieved on	A 025		

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A 025	Continued From page 9 /23clinicaltrials.gov/ct2/show/NCT04095819). A hospital emergency department record indicated the resident presented with a that occurred on that day. A , the hospital physical exam indicated "4 cm (centimeter) over frontal bone above right . Associated , hematoma." "A hematoma is a collection of outside of a . It occurs because the wall of a wall, , or , has been damaged and has leaked into tissues where it does not belong." (retrieved www.medicinenet.com/hematoma/article/htm). A hospital result indicated "acute 1.3 cm right supratentorial hematoma with associated effect and shift. Subacute 0.4 cm left parafalcine hematoma also noted". "A hematoma is a type of inside your . It's a type of that occurs within your but outside the actual tissue." (Retrieved my.clevelandclinic.org/health/ /21183-sub dural-hematoma). On at 11:13 AM, family reported that resident was transferred to at a different hospital. On at 4 PM, the resident returned from the hospital. A sitter was to be with her. A , 1823 assessment form indicated diagnoses of , hematoma, and . The health care provider ordered physical and , . The	A 025		

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A 025	Continued From page 10 resident was on . precautions. On ..... at 3:39 PM, the sitter and caregiver attempted to assist the resident to use the bathroom and change clothes. She began to use expletive language and attempted to hit staff multiple times. The nurse called for help. As soon as nurse attempted to change the resident, she hit the nurse multiple times in the middle of her . The Nurse Practitioner was notified and ordered for the resident to be sent to the hospital for . On 2:58 P.M. family reported resident being discharged from hospital to long term facility. On at 9:21 AM, a picture of a star was on the wall outside of a room in memory care. The name plates under the star indicated the residents in that room were residents #5 and #8. Caregiver A said the star was just a decoration. On at 9:25 at AM, Caregiver A said, "The star means they're a . risk; we have to watch them more closely." When asked which of the two residents was considered a . risk, she said both of them were. She then pointed to three circle magnets positioned on the upper right side of the outside door frame and said "same as these". There was a black one, red one and teal one. When I asked her what each color represented, she said the "code" for each color was posted in the laundry room. She returned with the poster that indicated black was for toileting, red was for falling star, teal was for hospice and clear was for meals. She said all the staff had access to the poster. She said the magnets for the room were for resident #5.	A 025		

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A 025	Continued From page 11 On . . . . . at 9:35 AM, Caregiver B said the star meant "They're the ones we have to help." When asked which of the two residents the star was for, she said for both of them. She could not remember what each magnet on the door frame meant, then said the codes were posted in the laundry room. On . . . . . at 9:40 AM, Caregiver C said the star meant for and said it was for both residents. She said, "it meant that she had to make sure the resident was in a safe position." She could not remember what each color the magnets represented then said she could look at the poster in the laundry room to remind herself. On . . . . . at 1:35 PM, resident #5 was seen lying in his low hospital bed. When asked if he calls staff to help him when he wants to get up and down, he replied "No, I just get up whenever I feel like it. On . . . . . at 2:49 PM, Caregiver D said that when resident #6 on at approximately 8 PM she tried to assist the resident to bed but the resident declined so she assisted the resident to sit on a sofa in her room and turned on the TV. She left the resident's room and closed the door. Approximately minutes later, she heard the resident calling for help. When she tried to enter the resident's room, she could not open the door fully because the resident was lying on the floor in front of the door. She called for help from Caregiver E. When she gained entry into the room, she saw the resident "had a gash on the side of her and there was a puddle of . . . . on the floor." She immediately called 911. She said the resident normally ambulated without the use of an assistive device. She said the star on the wall	A 025		

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A 025	Continued From page 12	A 025		

meant that resident was a high risk for [illegible] and had to be checked on every 30 minutes. She was aware that resident #5 was a [illegible] risk so when he was not in his room, she put him in a chair in the TV room otherwise, he rolled himself unsafely all around the unit. When she put him to bed, she made sure his bed was in the lowest position and a floor mat was down. She said she was trained on [illegible] and safety.

On [illegible] at 2:10 PM, Caregiver A said she was aware that residents #1, # 5 and #6 were all at risk for [illegible] so she checked on them every 30 minutes. She said she received training on the falling star program and on [illegible]/safety at least monthly.

On [illegible] at 2:34 PM, the Administrator said incident reports were completed but were considered an internal document and she's not allowed to give any to the surveyor per the vice president of clinical services. At 3:15 PM, the Administrator said the at-risk policy was revised in [illegible] and the only revision was that all paper documentation was changed to electronic. She said her first at-risk documented meeting was [illegible], and they've been done weekly since on [illegible]. She said a negotiated risk agreement was not completed for residents #1 and #5 as indicated in the [illegible] policy. She said resident #6 was not discussed during any of the at-risk meetings.

On [illegible] at 4:14 PM, the Administrator said a negotiated risk agreement was not done for resident #5. She said resident #1 was discharged before one could be done. Review of training documents revealed Caregiver A was present

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A 025	Continued From page 13 during a . . in-service on . . . . Caregiver E was present during one on . Caregiver B was not listed as a participant during any of them (, , ,). The Administrator said both Caregivers A and E should have known since they recently attended training. She said she could understand Caregiver B not knowing because "She just recently returned and was not here during these trainings." There was a lack of documentation to indicate the facility implemented interventions following the resident's . . On at 4:32 PM, the Administrator said the interventions are incorporated into the resident's service plan through "generalized" interventions but not " . ." specifically. The undated policy on the "Falling Star" program read, "Program: Evaluate at the weekly at-risk meetings. Review the residents who have had one or more in the past month. Implement interventions as identified and in collaboration with the team, resident, and responsible party. If no . . in 30 days, evaluate effectiveness of current service plan; ask: should the resident continue on the program? Or is there a need for a higher level of care? Have all avenues been exhausted to help the resident continue to be successful in memory care? Goal would be that within . . months all residents will have been discussed through your weekly at-risk meeting. Process: Morse . assessment to be filled out upon admission, quarterly, and with any change of condition. In PCC, the score is automatically to indicate low, moderate, or high risk of falling. Moderate risk should be considered for the falling star program. High risk is placed on the falling star program. A colored star will be placed outside their name on	A 025		

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	AL11964388	A. BUILDING: _____ B. WING _____	01/04/2023

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A 025	Continued From page 14	A 025		

the door of resident's apartment. Same color circle or star is also marked on the resident's name . Care associates are assigned a time on a.m. shift to escort the resident for a stroll in the courtyard outside, weather-permitting. If the resident utilizes a w/c, verify good sitting position prior to the movement and footrests, if needed. If walking next to the resident, the care associate should know whether distance or closeness will make the resident feel safer or agitate them. Provide the most comfortable way for the resident. Between PM, care associates will assist/encourage residents to an area, dim the lights and play soft music. Consider headphones for some residents. Offer massages with gloved , changing for each resident, and sanitizing in-between. Utilize any blankets or soft blankets on , , if possible. Another care associate would start assisting one or two residents for a bath or shower per preference scheduled time or assisting them with evening cares and preparing for bed. Provide lotion to arms and and when in bed, as resident will allow. While assisting the resident onto bed, place a few drops of lavender on their pillowcase. Outcomes possible: After the dinner meal, when they may be somewhat relaxed, this will assist with a calming environment to prepare for nighttime routine. Some residents may be at the end of sundowning, so the goal is to make a calming, relaxing, and soothing environment. The residents will start to get become accustomed to a routine. A decrease in agitation, restlessness and should occur. Moisturizing the resident's arms and will be good for skin integrity and observing the resident's skin each evening. Skin is moisturized, so the resident is less likely to feel itchy or restless when in bed, and will help with restless ."

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A 025	Continued From page 15 The undated policy read, "Should a resident experience a , associate will provide or arrange for necessary emergency care, and will follow up with necessary service plan updates. Procedure: Should the resident have resulting in deformity, exhibit any change in level of , received any injury, suspicion of injury or significant the administrator or caregivers summon emergency medical services (call 911). When a resident , caregivers are instructed to summon immediate assistance from the administrator nurse/assisted living director or another caregiver. Caregivers do not move the resident, except to protect against further injury, as in the case of a dangerous environment. The physician is contacted for further instructions if the was not involved in the and the resident is able to move all extremities. The administrator/assisted living director instructs caregivers to provide appropriate care and frequent resident checks. Any change in status is reported to the administrator. An incident report is completed. The administrator/assisted living director informs the physician of subsequent and instability. Medical intervention, , , , , , and/or gait analysis is arranged when residents remain a significant risk for . A negotiated risk agreement will be completed and reviewed with the residents and the family. Ongoing may require relocation from the community." Best Practice 2022 policy on Resident at Risk meeting read, "Practice: The resident at risk meeting is a standing meeting held every Wednesday. The team reviews each resident in all levels of care. The team develops, implements, and evaluates action plans for all residents identified as at-risk. Meeting protocol: Executive director leads the meeting.	A 025		

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A 025	Continued From page 16	A 025		

Documentation will be in the electronic health record under resident focus notes. Notes from the previous meeting and all incident reports are reviewed. The director of health and wellness and memory care manager should meet with care associates and third-party providers before meeting to get pertinent health information for meeting. All move ins are reviewed, and potential issues discussed. All projected move outs are discussed as to the reason for the projected transition and any potential interventions that would benefit the resident's health and safety and further their stay. Review residents with action plans in place from previous meetings and determine success of interventions or whether different interventions are necessary. The following resident criteria should be reviewed during the meeting: frequent ER visits, changes, , cognition changes, , , behavioral changes, skin integrity issues, financial concerns, resident/family grievances, out of community, new move ins, level of care transfers, re-admissions (hospital/rehab), hospice. The director of health and wellness will enter a resident focus note in the electronic health record for each potential at risk resident during the meeting. Prior week notes will also be updated with additional concerns. Post Meeting protocol: Documentation is maintained in the electronic health record under resident focus notes. Executive director will review progress on action items with the assigned responsible person one week after the meeting. Care plans are updated for any change in resident condition by the director of health and wellness or nurse. The resident's current level of care is reviewed along with the current care plan to determine whether the level of care needs to be changed. No discussion of cost or rate takes place at this meeting. Family and physician are

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A 025	Continued From page 17 notified of any change in resident condition by the director of health and wellness or nurse. When a change of condition . . outside of the scope of the community license, a third-party referral for service should occur. RDCS (resident director clinical services) will review the resident focused notes and discuss any related concerns with the team. The RDCS and director of health and wellness will help implement a care strategy using the three-tiered approach (30, 60, 90). First 30 days- when an at-risk resident is identified, a strategy is immediately developed to reduce the risk for move out or next level of care transition. Day 30-60- a plan is implemented, and the at-risk resident is returned to baseline or determined to be resolved the plan should determine the next steps for days 60-90. Day 60-90- if interventions and plan are not successful, team begins to develop a discharge plan and resident is transferred to the appropriate higher level of care. The discharge plan should meet the state regulatory guidelines for appropriate notice period." Class II	A 025		