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
	AL11965138	A. BUILDING: _____ B. WING _____	01/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DR PHILLIPS AL	8001 PIN OAK DRIVE ORLANDO, FL 32819

(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 #2022015837 was conducted on [redacted] and additional information was received on [redacted]. Brookdale Dr Phillips Assisted Living had deficiencies at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [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	A 025		

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A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide care and services appropriate to meet the needs of residents to minimize the potential for and injuries for 3 of 6 sampled residents (#1, #3 & #5). Findings: 1. A facility preliminary report on at approximately 12:15 AM revealed that resident #1 was found on the floor in his room next to his bed by caregiver D. The resident had coming from his , so caregiver D called 911. The	A 025		

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A 025	Continued From page 2	A 025		

resident was taken to the hospital. Prior to the , the resident was last checked on at approximately 10 PM by caregiver D. At that time, the resident said he did not need anything. The resident used his pendant to call for assistance and that was how staff found him on the floor in his room. On Friday at approximately 3:30 PM, the facility was notified by staff at the hospital that the resident had a C2 , a second of the .

Resident #1's record revealed a facility admission date of . An 1823 health assessment form, dated , included the resident's medical history of 's , , , and . He had and . He required assistance with bathing, , grooming, toileting and transferring.

The resident's record revealed the following documentation:

On at 6 PM - "Resident is a 2 assist with all transfers and needs assistance with ADLs (activities of daily living) . . . resident is able to make his needs known, given a pendant and voiced understanding how to use it."

An , , ( ) evaluation and an , , ( ) evaluation was done.

On at 6:10 PM - "Resident observed on the floor between his wheelchair and bed. According to the resident he was reaching for his glasses, yet he had them on. Denied hitting his . Small observed on his right . No reported. No other injuries observed."

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A 025	Continued From page 3 On .. .. at approximately 12:15 AM, the resident was found on the floor in his room next to his bed by caregiver D. The resident had .... coming from his so caregiver D then called 911. The resident was taken to the hospital. Prior to the , the resident was last checked at approximately 10 PM by caregiver D. At that time, the resident said he did not need anything. The resident used his pendant to call for assistance and that was how staff found him on the floor in his room. On Friday .. .. at approximately 3:30 PM, the facility was notified by staff at the hospital that the resident had a C2 ..... There was no facility documentation to indicate the facility implemented any proactive measures to prevent or minimize the potential for additional , a risk evaluation was not completed upon the resident's move in, there were no post- risk evaluations, no service plan was available for review, and there was no documentation to indicate the resident's were discussed at a collaborative care review (CCR) meeting. On .. .. at 9:37 AM - "Got report this morning that resident out of bed last night and he was sent to the hospital because of ... injury." On .. .. at 11:16 AM - "This nurse (previous director of nursing) was notified Friday afternoon ... . at approximately 3:30 PM that resident has a C2 by the nurse from (the hospital)." On ..... at 1 PM - "Resident's grandson came to the community at approximately 1 PM and notified staff that his grandfather was going to a skilled nursing facility for rehab, and he did not believe he would be returning."	A 025		

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A 025	Continued From page 4 On [redacted] at 12:38 PM the current director of nursing (DON) said the pendant call system saved call response details for only thirty days. 2. Resident #3's record revealed an admission date of [redacted]. An 1823, dated [redacted], indicated the resident's medical history included [redacted] and resolved right [redacted] and right [redacted]. She had [redacted] communication [redacted], short- and long-term memory loss and [redacted]. She required a front wheeled walker for ambulation and transferring and assistance with bathing, [redacted], grooming, toileting, ambulation and transferring. An 1823, dated [redacted], indicated additional medical history of [redacted] and [redacted]. She was forgetful and had fatigue and [redacted]. The resident's record revealed the following documentation: [redacted] at 12 PM - "resident able to stand and pivot with one person stand by assistance. Alert and oriented to person and place . . . Right arm [redacted] due to previous [redacted] that is healed according to family. Left [redacted] according to family and unknown cause. Resident is able to verbalize needs and understood how to use her pendant and demonstrated pushing it in front of this nurse." [redacted] at 11:25 AM - "Resident was observed on the floor in her bathroom. Per resident she was coming from the bathroom unassisted. She doesn't know what happened exactly. No injuries reported." [redacted] at 9:56 AM - "Resident was observed on	A 025		

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A 025	Continued From page 5 the floor by her door. She had [illegible] after coming from the bathroom unassisted. Cut was noted on her right [illegible]. 911 was called and resident was sent to hospital for evaluation." [illegible] at 11:19 PM - "Resident [illegible] to facility with right [illegible] injury and right [illegible] several staples. Hematoma noted. Unable to open right [illegible], redness to [illegible] and left lateral side [illegible]." On [illegible], the resident was admitted to hospice care. A [illegible] and a [illegible] Interdisciplinary care plan did not document any [illegible] interventions. [illegible] at 3:14 PM - "Resident wanted to sleep in this morning. Very groggy and disoriented. Resident states that she is in [illegible] all over and this nurse reported [illegible] to her doctor. Resident needs assistance with all ADLs and transfers. Very weak when transferring. Has [illegible] to her right [illegible] and has [illegible] above right [illegible]." A [illegible] hospital discharge summary indicated the resident was seen for a [illegible] with a [illegible] injury. No [illegible] or [illegible] were noted. [illegible] at 9:27 AM - "Resident was observed on the floor in her shower last night ([illegible]). She was asked how she got on the floor; she stated she didn't know but was complaining of left [illegible], [illegible] plus a bump was noticed on her forehead. EMT (emergency medical technician) was called, and resident was transferred to the hospital for evaluation . . . Resident was discharged after a few hours." A post-[illegible] evaluation did not indicate any interventions were implemented by the facility. [illegible] at 12:25 PM - "Reminded to use pendant for assistance."	A 025		

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A 025	Continued From page 6 at 10:14 AM - "Called to resident apartment at 10:05 Am. Resident lying down on floor in front of recliner. Checked for injury, none noted. 3 person assist to recliner. Vitals (vital signs) WNR (within normal range). Resident stated she was trying to get up but stumbled after she stood up and . Reiterated with resident to make sure she presses her pendant and wait for assistance before trying to stand. Pendant on and resident resting comfortably in recliner." A post- evaluation did not indicate any interventions were implemented by the facility. at 7:11 PM - "Resident had an unwitnessed this evening. Found next to her bed laying on her . Resident said she was trying to get into her bed and . Complained of right , was able to move up and down and bend . Complained of right , was able to move right arm and . Called daughter to notify her. Family refused for her to go to the hospital to be evaluated. After getting resident up and into recliner this nurse noticed a small purple colored bump on resident's right . Notified daughter who again agreed that resident would not go to the hospital and this nurse would call hospice to notify. Resident okay and requested an Ensure before leaving her room. Resident had pendant around her and verbalized understanding that she needed to use it before getting up." A post- evaluation did not indicate any interventions were implemented by the facility. at 7:26 PM - "Resident able to verbalize needs and reminded to use her pendant when wanting to transfer." at 2:14 PM - "Resident remains alert and	A 025		

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A 025	Continued From page 7 oriented to self with mild . . . . . and forgetfulness. Resident has frequent and is reminded frequently to use her pendant to call for assistance. Resident uses manual wheelchair for mobility, requires assistance with all ADLs, continues on hospice services." at 3:18 PM - "Called to resident apartment at 2:45 PM. Resident found lying on her in apartment bathroom, in the shower and . . . relaxed out in front. Noted redness to left forehead area and a knot to lower portion of . . . of . . . . Resident complaining of and tailbone area hurting . . . Called 911 to take to hospital for evaluations." No post-evaluation and no documented interventions were done by the facility. A . . . . . hospital discharge summary indicated the resident was seen for a with a injury. A computed . . . . . (CT) scan of . . . and , did not show any acute abnormalities. . . . . . at 8:23 PM - "Resident returned from hospital. Tests were negative for injury or . . . . . ." . . . . at 5:14 PM - "Resident was found in the hallway with and redness to the right . . She denies any , . . She is unaware of how she received the . . and redness." No post- . evaluation and no documented . interventions were done by the facility. at 10:00 AM - "Resident was observed on the floor in her bathroom. Per (resident assistant) resident tried to use the bathroom unassisted lost balance and . . Bump noted on the of her on the right side. Hospice	A 025		

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A 025	Continued From page 8	A 025		

was called and notified of resident's . Nurse was sent. She assessed resident and was put on crisis care for safety." A post- evaluation indicated the interventions implemented were "more teaching on the use of pendant for assistance" and "educate resident on the use of their emergency call system".

. . .. at 6 PM - "Resident was found in her apartment down in front of her bed and TV stand. . . . . was on the floor next to her, and the of her was covered in . This nurse asked her if she was ok and resident mumbled incoherent. Nurse told med tech to call 911. Ambulance arrived and resident was able to respond to some questions. Ambulance then took resident to the hospital." No post- evaluation and no documented interventions were done by the facility.

An . . .. hospital discharge summary indicated the resident was seen for a with a injury, ... of the . . . , ... indicated no acute findings and intact .. , ..

. . .. at 1 AM - "Resident returned last evening late in the night according to the overnight staff. Resident returned with bandage on her . . . . Complained of minor , this morning but was happy to be . . . . Resident reminded that she needs to use her pendant to call for assistance before getting up. Resident verbalized understanding."

at 3:54 PM - "Resident remains alert and oriented with forgetfulness . . . Resident encouraged to use her pendant for assistance."

at 2:38 PM - "Resident observed on the

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A 025	Continued From page 9 floor in the private bathroom. She had out of her wheelchair trying to transfer herself to the toilet. Resident noted with small open area on the left side of her and a bump. First aid applied." The resident's family did not want her sent to the hospital and to just let hospice come evaluate her. A post- evaluation did not indicate any interventions were implemented by the facility. at 10:34 AM - "Resident in the lobby as she was trying to transfer herself unassisted. Small scratch noted on the top of her . Family called and notified. They don't want resident to go to the hospital for evaluation." A post- evaluation did not indicate any interventions were implemented by the facility. at 4:21 PM - "Resident observed on the floor this evening laying on her right side. noted all over the floor. Resident assessed and she was on the right side of her and her middle left was deeply cut. Resident was alert and oriented. Stated she was trying to go to the bathroom unassisted. 911 called." A post- evaluation did not indicate any interventions were implemented by the facility. at 9:16 AM - "Resident returned from hospital last night, has 4 stitches on her forehead and wrapping on her left middle ."	A 025		
	at 6:40 PM - "Resident was found on the floor in her apartment bedside. Resident states she was attempting to get up and to her wheelchair. Noted lump to the of resident's ." No post- evaluation and no documented interventions were done by the facility.			

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A 025	Continued From page 10 at 6 AM - "Got report this morning that resident was found unresponsive this morning in her bed. 911 was called and resident was sent to the hospital." A hospital history and physical indicated the resident came in with complaint of , distress. Resident's daughter received a call yesterday from the assisted living facility (ALF) that the resident had . Resident has had multiple over this past year. Daughter subsequently received another call this morning from the ALF that they went to check on the resident and found her with her rolling in her . She also had some fluid coming out of her . Resident was brought to the emergency room. , showed and possible , . Resident's health care surrogate said the resident was on hospice and he did not want any aggressive measures. of the resident's revealed no acute . at 3 M - "Return from hospital alert and oriented with some , had dinner meal in the dining room. Pendant missing. 1823 received and new order meds received for , and . Hospice contacted." at 10:36 PM - "Resident's daughter reported she had a on Wednesday ( ) and went to the hospital on Thursday ( ). She had , and , 5 in the scale of 0-10. She had no done at the hospital to right arm and . Daughter requested for resident to have an done if this condition continues. New order received from hospital for and , Vitas was contacted. They will come to evaluate resident before transcribe	A 025		

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A 025	Continued From page 11 order meds and ." The decision was made to not do an , since the resident had just been at the hospital the day before. at 1:14 PM - "Resident observed with a left . Per resident she hit it on the door. Family called and notified." On , the physician ordered a bed rail to assist with transferring. There was no facility documentation to indicate the facility implemented any proactive measures to prevent or minimize the potential for additional , no risk evaluation was completed upon the resident's move in, no service plan was available for review and no documentation to indicate the resident's were discussed at a collaborative care review (CCR) meeting. On at 9:40 AM, resident #3 was seen sitting in a recliner in her room. When asked if she'd ever , she replied, "That's my life story, I cracked my one time and my . I usually walking one place or another." When asked when the last time was that she'd she replied, "I don't remember". A wheelchair was in her room. A bedside commode was next to her bed. The left side of her bed was against the wall and the right side had a " " type side rail. She said she needed help transferring. She said she used her pendant to call staff, who responded timely. On at 4:50 PM, nurse E said regarding interventions for resident #3, "I make sure she had her pendant, I check on her every hour and I tell the resident aides to check on her. She doesn't want to wear her pendant at night, so I put it next to her bed."	A 025		

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A 025	Continued From page 12 3. Resident #5's record revealed an admission date of [redacted]. An 1823, dated [redacted], indicated the resident's medical history included [redacted] and [redacted]. He was [redacted] at times, at risk for [redacted] and independent with ADLs and transferring. The resident's record indicated the following: [redacted] at 12 PM - "Resident transferred from our memory care facility. Ambulates with wheelchair." at 11:01 AM - "Received report this morning that resident was observed on the floor by his bed. Per resident he was trying to get in bed unassisted and his [redacted] gave in. resident didn't use his pendant. Was assisted up to bed but was complaining of lower [redacted], [redacted] so family was called, and resident was sent to hospital for evaluation. Resident returned this morning from hospital." at 1:59 PM - "Resident continues to ask for help during transfers and showers. Resident was observed this morning trying to give himself a shower." [redacted] at 2:28 PM - "Resident reminded to use his pendant for assistance." at 11:20 PM - "Resident called for assistance, this writer went to his room observed resident on the floor by his bed. Resident stated he was using toilet he tried to go [redacted] to bed he [redacted] from wheelchair to the floor, when assessed resident vital sign [redacted], [redacted] P 64 R 20 T 97.2 O2sat 95%. Resident hit his [redacted]. Bump noted to	A 025		

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A 025	Continued From page 13 left side forehead, left . . . . . , and complaining of right , . 911 called to transport resident to the hospital for further evaluation and treatment, family notified." . . . . at 4 AM - "Resident returned from hospital this morning via ambulance. noted on his left . . . and a small . . . . on his forehead. Resident states he feels tired but was able to come to the dining room for breakfast and meds administered as ordered." On at 9:50 AM, the resident was seen sitting in a wheelchair in his room. He wore socks on his . He sat with his to the room door. When asked about his recent hospital stay, he said, "They put a warrant out for my ." I asked him to elaborate more but the story he told was difficult to follow. When asked about his prior to going to the hospital he replied, "I slid and down on the floor yesterday about 9 o'clock in the evening. I was getting in my wheelchair from bed." He said he normally transferred himself. When I asked if he was supposed to have someone with him, he replied "I don't know". He said he pushed his pendant when he . and "it seemed like an hour" before staff responded. A purple nickel-sized was on his left forehead and a crescent-shaped, approximately 1 centimeter . . . . was on his left . . . . . When asked about the injuries he replied, "When I , boy did I hit hard. I was sitting on that . . . floor for six hours. My off the table and the floor was wet." A blanket was seen in his shower that had on it. A walker was in the room. He said sometimes he used it but mostly used the wheelchair. The left side of his bed was against the wall and the right side did not have a side rail. Review of the resident's pendant and pull cord report revealed the following:	A 025		

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	AL11965138	A. BUILDING: _____ B. WING _____	01/23/2023

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A 025	Continued From page 14 On , his bathroom pull cord was activated at 6:57 PM then reset at 10 PM, which was a response time of 3 hours 3 minutes. On , his pendant was pushed at 9:18 PM then reset at 10:22 PM, which was a response time of 1 hour 3 minutes. On at 3:18 PM, nurse C said the staff carried a pager that alerted them when a resident called on their pendant or pulled the bathroom cord. She said both required someone to go to the pendant or cord and manually reset them. On at 3:47 pm, the DON said she spoke with resident #5 about his on and he reported to her that "he was going to the bathroom and his went out on him. He pressed his pendant and waited a while and finally someone came in." The DON said she'd not yet started an investigation into the incident and that when the administrator returned on the next day, an investigation would begin. She said the ideal response time to call and pendants was 15 minutes. She'd not yet spoken with staff because she wanted to wait for the administrator to be present when she did. She said following the resident's first in , and were continued. She said his surgery was being scheduled after his surgery that was scheduled for next week. On at 4:20 PM, caregiver D said regarding resident #5's on , "While I was in the second-floor office, I heard a . I got there and he was on the floor. I called . He pressed his pendant, and it was responded to in less than five minutes. There was on the left side of his bed. He said he was trying to get	A 025		

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A 025	Continued From page 15 up. He said, "It was my fault, it was my fault." She said, "He was good about calling for help and I always made sure I checked on him every two hours." She said the pager system to receive resident calls functioned properly. On . . . . . at 4:50 PM, nurse E said that on at approximately 7 PM, she assisted resident #5 from downstairs to his room. She said caregiver F told her that the resident called for help, and she assisted him but forgot to turn the pendant off. Nurse E said she carried a radio around and it was only the caregivers who had pagers. The facility's policy defined a as "Unintentionally coming to rest on the ground, floor, or other lower level, either witnessed or unwitnessed, with or without injury." The policy indicated that a risk evaluation is completed at the time of move-in. A post- evaluation is completed after a resident , individualized interventions are considered, and the evaluation is part of the resident's record. When a occurs, document the resident's and injuries, resident's response, and interventions taken in the resident's record. The service plan is reviewed for potential interventions and updated as necessary. Discuss the resident's at the next CCR meeting. Review of a CCR meeting document, which was the only one provided by the DON, did not contain documentation to indicate resident #1's, #3's and #5's . . were discussed. Class II	A 025		

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A 034	Continued From page 16	A 034		
A 034 SS=D	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to develop policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device and failed to ensure 1 of 6 sampled resident's wheelchair was cleaned (#5). Findings: On at 9:50 AM, the lower frame of resident #5's wheelchair was found to be dirty.	A 034		

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A 034	Continued From page 17 The resident said the facility had never washed it. He was admitted to the facility on . The facility's Assistive Medical Devices policy did not contain the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. On at 10:56 AM, the director of nursing (DON) was asked if the facility had additional policies related to assistive devices. At 11:50 am, the DON provided a policy that pertained only to the use of gait belts. On at 4:36 pm, the DON said resident wheelchairs were wiped down weekly, but documentation was not maintained to reflect it. Class III	A 034		
CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled	CZ821		

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CZ821	Continued From page 18 person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at:	CZ821		

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CZ821	Continued From page 19 https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , , which is hereby incorporated by reference and available at:	CZ821		

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CZ821	Continued From page 20 http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to electronically submit to the Agency	CZ821		

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CZ821	Continued From page 21 for Health Care Administration (AHCA), a full report within 15 calendar days for 1 of 6 sampled residents having a condition who required the transfer from the facility to a hospital with an outcome of a [redacted] (#1). Findings: Review of a facility preliminary 1-day facility report revealed that on at approximately 12:15 AM, resident #1 was found on the floor in his room next to his bed by caregiver D. The resident had [redacted] coming from his [redacted], so caregiver D called 911. The resident was taken to the hospital. Prior to the [redacted], the resident was last checked on at approximately 10 PM by caregiver D. At that time, the resident said he did not need anything. The resident used his pendant to call for assistance and that was how staff found him on the floor in his room. On at approximately 3:30 PM, the facility was notified by staff at the hospital that the resident had a C2 [redacted], a [redacted] of the second [redacted] of the [redacted]. Resident #1's record revealed a facility admission date of [redacted]. An 1823 health assessment form, dated [redacted], indicated the resident's medical history included [redacted]'s [redacted] and [redacted]. He had [redacted] and [redacted]. He required assistance with bathing, [redacted], grooming, toileting and transferring. The resident's record revealed the following documentation: On at 6 PM - "Resident is a 2 assist with all transfers and needs assistance with ADLs (activities of daily living) . . . resident is able to	CZ821		

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CZ821	Continued From page 22 make his needs known, given a pendant and voiced understanding how to use it." An , , , ( ) evaluation and an , , , ( ) evaluation was completed. On at 6:10 PM - "Resident observed on the floor between his wheelchair and bed. Per resident he was reaching for glasses, yet he had them on. Denied hitting his . Small observed on his right . No , reported. No other injuries observed." On at 9:37 AM - "Got report this morning that resident out of bed last night and he was sent to the hospital because of injury." On 11:16 AM - "This nurse (previous director of nursing) was notified Friday afternoon at approximately 3:30 PM that resident has a C2 by the nurse from (name of hospital)." On at 1 PM - "Resident's grandson came to the community at approximately 1 PM and notified staff that his grandfather was going to a skilled nursing facility for rehab and he did not believe he would be returning." A final 15-day report was not located in any of the records reviewed, so a request for it was made to the DON. On at 3:25 PM, the DON said she did not know whether a 15-day report was completed. She tried to get hold of the previous DON, who was employed at the time of the event, without success. She said the administrator also could not locate a report on AHCA's electronic portal to	CZ821		

Agency for Health Care Administration

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CZ821	Continued From page 23 indicate the report was submitted, as required. Unclassified	CZ821		