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
	AL11968474	A. BUILDING: _____ B. WING _____	02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONTE VILLAGE OF LAKE MARY-CORDOVA	1001 ROYAL GARDENS CIR LAKE MARY, FL 32746

(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 #2023002210 was conducted on [redacted] & [redacted]. Oakmonte Village of Lake Mary - Cordova had deficiencies at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or [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		

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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 resident record review and interview, the facility failed to maintain written documentation and specific updates for 1 of 3 sampled residents (#1) regarding . . . . . investigation. Findings: A facility report dated at 2:45 PM revealed housekeeper B observed caregiver A smacking resident #1 on the and arm. Housekeeper B left work for the remaining of the day leaving caregiver A alone with resident #1. Housekeeper B did not report to management until the next day .	A 025		

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A 025	Continued From page 2 There was no documented evidence or facility notes written regarding the alleged . . . . . incident on at 2:45 PM involving resident #1 and caregiver A. The last written facility note dated at 10:42 AM as a late entry, revealed that resident #1 was seen by the podiatrist and tolerated the visit well. Photographic evidence was obtained. On . . . . . at 3:30 PM, an exit interview with both Administrator and Executive Director of Memory Care confirmed the findings. Class III	A 025		
A 030 SS=G	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	A 030		

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A 030	Continued From page 3 full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents 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.	A 030		

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A 030	Continued From page 4 (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 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 . . . . . 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	A 030		

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A 030	Continued From page 5 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 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	A 030		

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A 030	Continued From page 6 harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally [illegible], 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 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 [illegible], 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, [illegible], 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 [illegible] Hotline operated by the Department of Children and Families, and, if applicable, [illegible], Rights Florida, where	A 030		

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A 030	Continued From page 7 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 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:	A 030		

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A 030	Continued From page 8 Based on facility documentation, record review and interview, the facility failure to honor 1 of 3 sampled residents' rights by not following the facility's , neglect and , policy and procedures, and not immediately reporting the to management before leaving the facility's premises (#1). Findings: Resident #1's record revealed an admission date of . The last 1823 Health Assessment dated with medical history including , , , , and , . She has an unsteady gait with balance and a precaution. She needs assistance with activities of daily living (ADLs) for bathing and , supervision with eating, grooming and toileting, and assistance with self-administration of medications. A facility report dated at 2:45 PM, revealed housekeeper B observed caregiver A smacking resident #1 on the and arm. Housekeeper B left work for the remaining of the day leaving caregiver A alone with resident #1. Housekeeper B did not report to management until the next day . On at approximately 12 PM, the Executive Director of Memory Care said that she called the hotline, reported the incident, and waited for the investigation. At 2:30 PM, when Caregiver A showed up to work for the day, the Executive Director of Memory Care suspended her immediately pending investigation. On at 8:50 AM, a follow up email was sent to resident #1's family by the Executive	A 030		

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A 030	Continued From page 9 Director of Memory Care. On . . . . . at approximately 10 AM, both the local law enforcement officer and the adult protective investigator completed their investigation at the facility. On at 11:16 AM, the incident for resident #1 by caregiver A was reported to the Agency for Health Care Administration. The facility's " , neglect, and , (ANE)" policies and procedures read in part, "Failure to report the suspicion or knowledge of the same by an employee is considered unacceptable conduct and may result in disciplinary action, up to including termination. Furthermore, any , neglect and , allegations by any persons has the right to pursue their concerns through a formal process and be investigated. All employees must report . . . . . , neglect, and , immediately and call the . . . . . hotline telephone number." Photographic evidence was obtained. On at 12:30 PM, an interview with Housekeeper B confirmed that she reported the to resident #1 from Caregiver A on . . . . . , the next day, to the Executive Director of Memory Care because she wanted to keep it confidential and did not want her co-workers to gossip about it. Housekeeper B stated that approximately at 2:40 PM on . . . . . right before she was ending her work shift, Caregiver A called out loud to her in the hallway asking for some extra towels. Housekeeper B went to the laundry room to retrieve the towels and took them to resident #1's room. When Housekeeper B entered resident #1's room, she saw resident #1 wrapped in a purple towel and was sitting on a	A 030		

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A 030	Continued From page 10	A 030		

. . . . . chair and observed the bathroom floor was wet so she went to clean up the excess water off the bathroom floor. Housekeeper B said as she was coming out of the bathroom, she saw Caregiver A slap resident #1 across the left side of the with such force that resident #1 lifted from the footstep chair where she was sitting still wrapped in the purple towel. Resident #1 lifted off the footstep chair where Housekeeper B saw feces on the footstep chair. Housekeeper B said that resident #1 was trying to move from the footstep chair where she had defecated onto her recliner chair, but Caregiver A grabbed resident #1 with force by the arm and preventing her from sitting in the recliner chair. Caregiver A then started yelling at resident #1 again saying "No, you are not going to that recliner chair to dirty" and continuing yelling at resident #1, "You [expletive] on yourself." Housekeeper B said she was in with what she had just seen and heard. She had to leave work because her uber ride was outside waiting for her and she left Caregiver A and resident #1 alone in the room. Housekeeper B said that she cried while riding in the uber on her way home about what had happened. Housekeeper B said she was in that Caregiver A would do this to resident #1. Housekeeper B said that she never experienced any . . . . . or situation like that on the job but had heard about these cases on the news. Housekeeper B said she knew Caregiver A well on a personal level and did not expect Caregiver A to hit resident #1. Housekeeper B said that she and Caregiver A have a personal relationship outside of work as they have gone to the hospital and Dr. , , together in the past. Housekeeper B was asked if she had . . . . . , neglect and , training and resident rights training. She answered "No" at first, then said she did remember after it was shown that

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A 030	Continued From page 11 she completed the training on . Housekeeper B said the only training she remembered completing was the fire drills, ( ) and elopement trainings but was not sure. Housekeeper B was asked if she had any refresher trainings since her hire date, and she answered "No". She said that she would like refresher trainings. It was further explained that she must report any , neglect, , to any resident immediately per the facility's policy and that she was a mandatory reporter by law. Housekeeper B said that she was in as she never experienced an incident like that in the workplace and that she did not remember to report it at the time but agreed that should have been done. Housekeeper B said she wrote a witness statement to both law enforcement and DCF on but not a witness statement for the facility. On at 3:22 PM, the Executive Director of Memory Care confirmed that Housekeeper B reported the incident by Caregiver A to resident #1 that occurred on at 2:45 PM to her the next day on at 11:30 AM. The Executive Director of Memory Care stated that the manager on duty working on was Food Manager G. On at 10:45 AM, Food Manager G speaks a little English. He said that he had been working at the Memory Care for 3 years. He came from the independent living side originally. He said that he is the food manager for Memory Care, Monday-Friday but once every few months must work weekends as manager on duty. He confirmed that he was the manager on duty this past Sunday on and his work time was 9 AM to 4:45 PM. He stated he was not aware	A 030		

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A 030	Continued From page 12 and did not know that an [redacted] incident occurred by Caregiver A to resident #1. He said he did not find out about the [redacted] until on [redacted] at 10 AM, the next day at a meeting with the Executive Director of Memory Care. He said he went to talk further to the Executive Director of Memory Care and was asked to write a witness statement today on [redacted]. He said at the time of the [redacted], he went to lunch, returned, and checked the facility grounds outside, checked some keys and wrote up his manager's report. He confirmed that he had no other information to provide regarding this. He said he had [redacted], neglect and [redacted] training and knows to report immediately to the Executive Director. He added that he was surprised that no staff reported to him on [redacted]. On [redacted] at 11:30 AM, the Executive Director said she asked food manager G to write a witness statement. He said he was working but did not know anything happened and no one reported anything to him. On [redacted] at 2:24 PM, Medication Technician (Med Tech) E revealed on [redacted], he was at lunch when the [redacted] occurred by Caregiver A to resident #1. Med Tech E said he was never aware anything took place that whole evening shift. He said he could not believe Caregiver A or anyone could do this to a [redacted] elder. Med Tech E said that he started hearing the [redacted] circulating on [redacted] among co-workers. Med Tech E said that Caregiver A was always very helpful toward her co-workers, but she had a rough demeanor about her. He said that if it was him that had observed the [redacted], he would have called the police immediately on his cell phone, then call the Executive Director, told Caregiver A to leave the room, and he would have stayed with	A 030		

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(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 030	Continued From page 13 resident #1 until further instruction by his supervisor. Med Tech E stated he only had the [redacted], neglect and [redacted] training and resident rights training when he was hired in the beginning. Med Tech E said he completed a bunch of forms and might have had the training then almost a year and a half ago. He said he never completed any [redacted] -to- [redacted] in-service trainings. On [redacted] at 3:30 PM, an exit interview with the Administrator and Executive Director of Memory Care confirmed the findings. Class II	A 030		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of	A 081		

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	AL11968474	A. BUILDING: _____ B. WING _____	02/09/2023

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A 081	Continued From page 14 completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of	A 081		

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A 081	Continued From page 15 compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty	A 081		

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A 081	Continued From page 16 (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 7 staff (B & E) completed the required staff in-service trainings. Findings: 1. Staff B's personnel file revealed a hire date of [redacted] as a housekeeper. It revealed documentation of completed in-service training's for resident rights, reporting adverse and major incidents, recognizing and reporting on [redacted]. On [redacted] at 12:30 PM, staff B stated she could not remember receiving these trainings described above. 2. Staff E's personnel file revealed a hire date of [redacted] as a direct caregiver. It revealed documentation of completed in-service training's for resident rights, reporting adverse and major incidents, recognizing and reporting [redacted] on [redacted]. On [redacted] at 2:24 PM, Staff E stated said he did not complete any [redacted] -to- [redacted] in-service training on any of those topics.	A 081		

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A 081	Continued From page 17 Class III	A 081		
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the background screening	CZ814		

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CZ814	Continued From page 18 clearinghouse information was accurate for 1 of 7 staff (A). Findings: On , the background screening clearinghouse for staff At confirmed a hire date and an end date of . On at 3 PM, the administrator confirmed staff A was hired on and terminated not . She stated it must have been a clerical error. Photographic evidence was obtained. Unclassified	CZ814		