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
	AL11968157	A. BUILDING: _____ B. WING _____	R 03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENADES BY	425 S RONALD REAGAN BLVD LONGWOOD, FL 32750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A revisit to complaint investigations #2022014867 and #2022017542 was conducted at Serenades by on . The facility had an uncorrected deficiency 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 or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	{A 025}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 025}	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on observations, record reviews and interviews, the facility failed to document the presence of on 1 of 2 sampled resident's arms and failed to follow its policy on skin conditions as it related to completion of an incident report for the (#11). Findings: Review of resident #11's record revealed she was admitted to the facility on . A 1823 indicated her diagnoses included 's with a communication	{A 025}		

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{A 025}	Continued From page 2 and that she required assistance with bathing, , ambulation and transferring. On at 10:06 am, resident #11 was seen sitting in a wheelchair in the memory care dayroom. She had purple on both of her . {both measured approximately 3cm x 3cm) and on top of her left (approximately 2cm x 2cm.) When asked if something happened to her arms, the resident said "no". Nurse K and the corporate operations , were present. The nurse said she did not know how the occurred. A move-in skin assessment did not indicate she had . A and a health care provider's note did not indicate she had the . Facility notes did not indicate she had the . Review of her medication list revealed she did not take a . Review of the shower schedule revealed she was to receive a shower every Monday, Wednesday, and Friday during the 3pm-11pm shift. Review of a care tracking sheet revealed she received a shower on , , , and . Instructions on the sheet indicated that staff will report any noted changes in skin integrity to the nurse. A skin policy read that an incident report is to be completed for unusual skin conditions (, ,). On at 11:55 am, caregiver M said	{A 025}		

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{A 025}	Continued From page 3 regarding the [redacted] "her skin is very sensitive" then said "she came with that". On [redacted] at 12 pm, caregiver D said she dressed the resident that morning. When asked about the [redacted] she said "it's old. Her skin is really like an onion. I put lotion on her". On [redacted] at 12:05 pm, nurse K said the last time she worked was on [redacted]. When asked if she'd seen the [redacted] prior to today she replied "not really. She always wears long sleeves with a sweater". She then said she recalled that over time she'd seen red areas on the resident's arms but to what degree, she could not say. She said the resident's skin is thin and fragile and the staff tried to be careful with her during showers and when lifting her. She said the care staff never reported any [redacted] to her, other nurses never said anything during change of shift report and no skin concerns had ever been documented on the 24-hour reports. She said the nurses did not conduct skin checks on the residents. On [redacted] at 12:20 pm, the regional director of wellness said the nurses conduct a skin check during their monthly assessments. On [redacted] at 2:10 pm, nurse G, who conducted the admission skin assessment, said regarding the [redacted] "she had those when she came here". When told she did not document them she said "I didn't look at it as anything. She's looking better". When asked if she'd seen them since they did not have the appearance of healing [redacted] she replied "no, we don't do skin checks". She said the resident's arms were fragile and said "they are so gentle with her" (referring to the care staff). On [redacted] at 2:15 pm, the regional director of	{A 025}		

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{A 025}	Continued From page 4 wellness said she could not access the care tracking sheet on the computer. She also said an incident report was not completed for the . On at 2:20 pm, the resident's -sized bed was found to be positioned in the middle of her room and did not have side rails. On at 2:25 pm, observations made during a transfer of the resident from her wheelchair to the toilet and revealed she used a bar to pull herself up each time. Caregivers D and M, who were both present, said the resident was also able to stand by pushing up on the wheelchair arm rests when transferring to and from her bed. On at 2:36 pm, the resident's son said she had a in the rehab facility prior to coming to this facility, but he was not sure if she sustained on her arms and at that time. He said his mom was always and always wore long sleeves, so he had not seen the . On at 3:25 pm, the were looked at with nurse G and the regional director of wellness. Nurse G said "that's the same thing, nothing new" (pertaining to the existence of them when the resident was admitted). Class III	{A 025}		