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
	AL11966928	A. BUILDING: _____ B. WING _____	04/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD ASSISTED LIVING, INC	325 NORWOOD ST MERRITT ISLAND, FL 32953

(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 #2023000204 was conducted on . Norwood Assisted Living had a deficiency identified at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or 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

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
	AL11966928	A. BUILDING: _____ B. WING _____	04/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD ASSISTED LIVING, INC	325 NORWOOD ST MERRITT ISLAND, FL 32953

(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 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 record reviews and interviews, the facility failed to provide adequate supervision and care and services appropriate to meet the needs to ensure safety through proactive measures to minimize the potential for and injuries for 2 of 4 sampled residents who experienced repeated with injuries. (#1 & #2). Findings: 1. Resident #1's record review revealed she was admitted on . Her record contained a Resident Health Assessment form (1823) dated . Her diagnoses included major , and	A 025		

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
	AL11966928	A. BUILDING: _____ B. WING _____	04/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD ASSISTED LIVING, INC	325 NORWOOD ST MERRITT ISLAND, FL 32953

(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 025	Continued From page 2 . She required assistance with ambulation, bathing, , toileting, and transfer and supervision with grooming and was a risk. Review of the facility notes revealed: - "Resident backwards at breakfast time. 911 assessed her and did not take her to hospital." - "Resident sitting on the floor." - "Resident in dining room to ." - "Found on the floor at 8pm no injury left ankle ." - " done." (Not in the record) On at 10:30 AM, the owner said the , was negative. Review of the facility report dated for resident #1 revealed that around 8 AM, staff A heard resident #1 talking to herself. She went to her room and found the resident on the floor. Staff A said the administrator noticed the resident was limping and her right ankle was . The resident was sent to emergency room (ER) for an evaluation. Resident #1 sustained a closed nondisplaced of the lateral malleolus of the right . On at 11:30 AM, staff A said resident #1 in her room early in the morning. She heard her calling for help. Staff A assisted her to sit on the bed. Resident #1 did not complain of any , at that time. She said the resident walked to the living room for breakfast. Staff A noticed her ankle was after lunch. Staff A says they asked resident #1 to sit in a chair so she would not . 2. Resident #2's record review revealed she was admitted . Her diagnoses included	A 025		

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
	AL11966928	A. BUILDING: _____ B. WING _____	04/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD ASSISTED LIVING, INC	325 NORWOOD ST MERRITT ISLAND, FL 32953

(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 025	Continued From page 3 memory loss, unsteady gait, and generalized . Review of the facility notes revealed resident #2 was found on the floor in her bathroom on at 4:15 AM. She was transferred to the hospital via ambulance with a diagnosis of , . On at 11:35 AM, staff A confirmed resident #2 in the bathroom at 4 AM on . The resident did not have her walker with her. Staff A said she heard her calling for help. Emergency Medical Services ( ) was called to pick her up and they took her to the hospital because she complained of , , . On at 11:45 AM, the Owner/Administratorconfirmed resident #1 had multiple . She said resident #1 because of her levels. She could even when sitting. She said her psychiatrist does the medication levels. The lab work is not kept in the facility records. She said they try to have resident #1 sit in a chair so they can keep an on her as much as possible. They also put an alarm on her bed at night. Requested a policy from the owner/administrator. She confirmed she was unable to provide it.. Class II	A 025		