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
	AL11969463	A. BUILDING: _____ B. WING _____	04/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MADYSON AT PALM BEACH GARDENS	13465 PASTEUR BLVD PALM BEACH GARDENS, FL 33418

(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 An unannounced Relicensure with Extended Congregate Care (ECC) survey, Complaint (#2022005123, #2022009755, #2022014992, #2022018339, #2023004671, and #2023005268) survey, and a Generator Monitoring survey were conducted on [redacted] at The Madyson at Palm Beach Gardens. The facility had deficiencies identified related to the Relicensure at the time of the survey.	A 000		
A 025	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.	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 (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. (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 review and interview, the facility failed to ensure prevention measures were initiated for 1 out of 6 sampled residents reviewed for {Resident #15}. The findings included: Resident #15 was admitted to the facility on with a diagnosis of . The Resident Health Assessment (AHCA Form 1823)	A 025		

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A 025	Continued From page 2 dated ... noted that the resident had a history of , had poor vision and hearing, was very weak and very ..., and was on hospice. It was noted that she required "special precautions". She resided in the Memory Care Unit, and needed "assistance" with transfers and toileting and "total" care with ambulation as documented on the assessment. On , Resident #15's record notes she was found on the floor next to her bed at 11:15 PM. She stated, "I my left , hurts" and was transported to the hospital. The facility's Incident Investigation report documents the "Follow Up and Prevention" as "General; Environmental Modifications; and, Assistive Devices Added". The resident's record revealed no assessment of the reason for the , and no specific interventions initiated to prevent further recurrence of or minimizing injury from subsequent ... On ... at 6:30 PM, Resident #15 was noted as sustaining an injury of unknown origin on a Resident Incident Report. The report indicated the resident had ␣ and ␣ of her lower extremities identified by staff while in bed. An Adverse Incident Report was filed with the Agency, noting that the resident sustained the injuries on (different date) at 5:10 PM and that hospice was notified. There were no interventions noted to prevent after the identified injury of unknown origin. An ␣, completed on documents that the resident sustained an "acute ... (more than one place) impaction identified right , with ...". The Adverse Incident Report documents that the reason for this injury is unknown, and included no documentation of interventions initiated to prevent further	A 025		

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A 025	Continued From page 3 recurrence other than "staff will be in-serviced regarding reporting and documenting resident [illegible]". Class III	A 025		
A 165	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or	A 165		

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A 165	Continued From page 4 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to	A 165		

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A 165	Continued From page 5 disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure one and fifteen day Adverse Incident Reports were completed and submitted as required for 3 out of 7 sampled residents (Residents #4, Resident #9 and Resident #15). The findings included: A. On at 5:00 PM, the facility's Initial Record of Incident report for Resident #9 documents that the resident was "found on the floor in the dining room bathroom" and that the resident was "unable to explain the ; complained of , to left ". The resident was sent to the hospital for evaluation. On , review of a Progress Note shows the resident was diagnosed with a "left , ".	A 165		

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A 165	Continued From page 6 Review of the County Fire Rescue report dated notes documents "cause of injury" as " from chair". The report also documents that "staff advised crew that patient was in the dining hall and attempted to sit in her chair and missed the seat causing her to onto the floor. Staff state that the was witnessed...". The County Fire Rescue report identifies a discrepancy to the facility investigative report stating the resident was found on the floor in the dining room bathroom when the resident's incident occurred in the dining hall. During a telephone interview conducted with the resident's representative on at 3:15 PM, she stated that the resident her , and did not return to the facility after the on . During review on of Adverse Report filings with the Agency from this facility for , there were no Adverse Incident reports found to show the facility's investigation, including interviews with staff, an accurate description of the circumstances, and to determine the possible cause of the Resident #9's with interventions to prevent recurrence. The facility failed to file an Adverse Incident Report (one and 15 day) with the Agency for the sustained by Resident #9 on . B. On , an , ordered by Hospice was completed on Resident #15's lower extremities which resulted in a diagnosis of a right , of unknown origin. The resident was sent to the hospital on for a surgical evaluation. Review of the Report Status History on the	A 165		

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A 165	Continued From page 7 Adverse Report that was filed with the Agency for this reveals the facility submitted the report on , more than one business day after the incident. C. On , the Power of Attorney for Resident #4 notified the facility that 2 personal checks were missing from Resident #4's checkbook. Resident #4 was unable to recall events due to . On , the Director of Nursing notified the Department of Children and Families (DCF) and local Law Enforcement of the incident. Staff F and Staff G, who were identified as being involved in the incident, were suspended immediately, and then later terminated on . Law Enforcement and DCF began an immediate investigation into the incident. Law Enforcement's investigation is currently still active. On , a review of the Facility's Investigation Notes regarding the misappropriation of funds for Resident #4, which had occurred on , revealed that an Adverse Incident Report had not been submitted by the facility for this event. Review of Agency's Background Screening Clearinghouse showed Staff F had a Level II BGS and was eligible for hire on . Staff F was hired on . Staff G had a Level II BGS and was eligible for hire on , and she was hired on . Per an interview conducted with the Assistant Administrator on at approximately 3:45 PM, the Assistant Administrator stated that an Adverse Incident was not filed because the facility	A 165		

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A 165	Continued From page 8 did not think it fit "adverse" guidelines based on determination that that facility had done everything it could to try to prevent the incident by completing Background Screenings and required Trainings. The Administration had felt that the event was not due to any fault on the part of the facility, only the individual actions of 2 staff members, and there was no way for the facility to . . . . . the actions of these employees beforehand. The facility believed that by immediately notifying DCF and Law Enforcement, they had fulfilled their requirements. The Administration staff were informed of the ALF regulation regarding adverse incidents, specifically 'An event that is reported to law enforcement or its personnel for investigation'. Class III	A 165		