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
	AL11968448	A. BUILDING: _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENADES BY -WEST ORANGE	720 ROPER ROAD WINTER GARDEN, FL 34787

(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 Relicensure survey with Limited Nursing Service (LNS), a Generator Monitoring and a Complaint Investigation #2022018106 were conducted from and . Serenades by -West Orange 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 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 025		

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A 025	Continued From page 1 (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 observations, record reviews and interviews, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for and injuries for 2 of 11 sampled residents (#6 & #11). Findings: 1. Resident #6's record revealed she was admitted to the facility on . Her diagnoses included , , , and	A 025		

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A 025	Continued From page 2 , . A and a , the health assessment forms (1823) indicated that she was alert with severe , required assistance with bathing, , grooming, toileting, transferring and ambulation and was at risk for . A facility initial evaluation indicated she had one or fewer within the last 6 months. reduction strategies were , for strengthening/balance, staff will encourage her to wear appropriately fitted and non-skid footwear, staff to assist with keeping walkways clear, staff/family/visitors should observe for changes in balance and safety awareness and report noted changes to the nurse. Nursing will evaluate and report changes to the primary care provider and responsible party as needed. A individual service plan listed the same interventions. A facility mobility/ risk criteria indicated a "yes" response to several of the questions indicated someone who may be at moderate to high risk for altered mobility or . Nine "yes" responses were answered on her criteria. On a health care provider ordered physical and occupational therapies. An 30-day evaluation and an service plan both indicated the same reduction strategies as those documented on . On at approximately 9:20 PM, she was observed lying on her left side on the floor next to her bed. She was alert. When asked what happened, she responded in Spanish. A large,	A 025		

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A 025	Continued From page 3 dark area of discoloration was noted on her left lateral lower . Staff said the was present before the . Staff said the resident would continue to be checked throughout the night. She was being treated for a at that time. The mobility risk criteria form was not completed. An post investigation indicated the option for a hospital bed with rails was added to the negotiated risk agreement (NRA). On at 2 AM, she was observed sitting on her bathroom floor with no apparent injuries observed by staff. On at 8:20 PM, she was observed on the floor next to the common area sofa with her outstretched. She could not hold her upper body up, so she was lying down on the floor. Her wheelchair was next to her. She could not say what happened. A slight red line was seen on her left upper . The mobility risk criteria form was not completed. A post investigation did not have any interventions. On at 11 PM, she was found on the floor lying by her bed. A mat was on the floor next to her bed. A post- investigation did not contain mobility risk criteria completed. On at 11 PM, she was on the floor by her bed. A post- investigation did not contain mobility risk criteria completed. On at 1:15 PM, she was found sitting upright on the floor mat next to her bed. A post- investigation did not contain mobility	A 025		

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A 025	Continued From page 4 risk criteria completed. A change of condition evaluation and service plan both had strategies based on what was already on the NRA. A NRA indicated the course of actions for her where the family could purchase a high/low bed and assess her footwear and remove shoes that do not have non-skid soles. On at 6:30 PM, she was observed sitting on her on the floor in the common area with her wheelchair behind her. The caregiver pushed the resident in her wheelchair and said she slipped off the chair. A post- investigation did not contain mobility risk criteria completed. On at 8:45 PM, discoloration/redness was seen on her . The area was palpated by staff, she flinched and said it hurt when touched. The area felt a little warm. She had a on but there were no visible injuries at that time according to staff. On at approximately 6:15 PM, she was seen lying on the floor in front of her wheelchair in front of . She was alert and had no apparent injuries. A nurse was going to ask hospice care for a wider wheelchair because her current one was not large enough. The mobility risk criteria was not completed. A post investigation indicated new interventions implemented were "NRA". On , she self-propelled throughout the unit. A NRA indicated the course of action for	A 025		

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A 025	Continued From page 5 her was a culture to check for a could be indicated, assess footwear, and remove shoes that do not have non-skid soles, personal pressure alarm, family could purchase a high/low bed. On at approximately 5:30 PM, she was seen lying on the hallway floor in front of on her right side. She was sleepy but awake and her wheelchair was behind her. Per care staff, she slid out of the wheelchair. The mobility risk criteria was not completed. A post- investigation indicated new interventions implemented were, "NRA on file". On , a health care provider ordered half-side rails on her bed to aid in independence with transfers and bed mobility. On at approximately 5:30 PM, she was seen lying on the floor outside of the dining room and on her left side. She was awake and answered questions. An egg-sized hematoma was on her forehead and an on the bridge of her . 911 was called and she was transported to a hospital. A post investigation read, "NRA in place, re-evaluate upon resident's return from rehab." On at 3:10 PM, she returned from the hospital. She had a hematoma and on her forehead, on both , and under both and on her arms and . She was to wear a brace 24 hours a day. A mobility/ risk criteria indicated she may be at moderate to high risk for altered	A 025		

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A 025	Continued From page 6 mobility or . . based on ten "yes" responses. On . . . . . at 10:15 AM, she sat in a high-. . . wheelchair near a counter in the dining room. The brakes on the chair were engaged. She sat in the middle of the chair and a pillow was behind her. Caregiver D walked over and instructed the resident to sit further in the chair but, the resident became agitated and did not do it. The caregiver said the resident did have a chair alarm when she used a standard wheelchair but when hospice services took that chair , they probably took the alarm . . . too. A standard wheelchair was seen in the resident's shower, half-rails were on her bed and a floor mat was under the bed. The bed was in a low position. An alarm was not seen on the standard wheelchair, not seen in her room, not seen on her bed, and not seen on the high . . . wheelchair. On . . . . . at 11:20 AM, a hospice team manager said a bed alarm was delivered to the facility on . . . . . and never picked up by a hospice representative. On at 11:45 AM, the director of nursing (DON) said the facility was not allowed to use safety alarms based on state regulations. He said the resident did not have an alarm and he would look at the order. On at 12:25 PM, the DON said he verified facility documents and indicated a pressure , . . alarm would be used for this resident. He said he confirmed with hospice services that one was delivered on . He said he searched the resident's room and the room next to hers and did not find it. He said all the caregivers said they never saw an alarm.	A 025		

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A 025	Continued From page 7 On [redacted] at 3:15 PM, the administrator provided two in-service sign-in logs, dated "[redacted]" and "[redacted]", that each had the [redacted] policy attached. Both trainings had the same two staff participants. On [redacted] at 3:45 PM, nurse G said when she walked onto the unit on [redacted], the resident was lying on the carpeted area right outside the dining room. She was lying on her left side in front of the wheelchair. She said the resident was very quiet, so she knew right away something was wrong. She did not touch the resident and instead called 911. She said she reached out to hospice on two prior occasions before that [redacted] and asked them to provide a wider wheelchair but that was not done. On [redacted] at 4:14 PM, caregiver B said when resident #6 [redacted] on [redacted], she was in the laundry room when she heard a noise. She came out to see what happened and saw caregiver H was with the resident. Caregiver B said the resident used to propel herself around in the standard chair, bend over to pick stuff off the floor, tried to fix her socks, remove her [redacted] bracelet device, and go into other resident rooms. She said that since the resident was now in a high-[redacted] chair, it can be reclined [redacted], and the resident was not as active as before the [redacted]. She said she received training on how to transfer residents and to call the nurse. She recalled being given [redacted] related papers and taking online training. On [redacted] at 4:36 PM, caregiver H said she was exiting another resident's room on [redacted] when she heard a resident screaming. She then saw resident #6 lying [redacted] down on the floor near the dining room. The resident's wheelchair was behind her. She said the resident had a history of sliding out of that [redacted] chair. She could not	A 025		

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A 025	Continued From page 8 remember if she ever received training on the facility's policies. A hospice and facility integrated plan of care did not list any prevention measures to be taken by either provider. A hospice updated plan of care indicated both a mat and bed alarm were ordered. 2. Review of resident #11's record revealed a facility admission date of . A 1823 assessment form revealed she required precautions. She was hard of hearing, her vision was , was "alert and oriented" and forgetful. She was independent with walking, toileting and transferring. Her medical history included moderate , , , and . A health care provider's visit note indicated she required a 4-wheeled walker to walk short distances, had a history of , in multiple sites and , unsteady gait, and poor balance, positing a significant risk. A initial facility evaluation indicated preventions were: observe for changes in balance and safety awareness and report noted changes to nurse; nursing will evaluate and report changes to primary care provider and responsible party. A service plan indicated the same. A NRA related to indicated one intervention, assess footwear and remove shoes that do not have non-skid soles. A at 11:20 AM facility note indicated she walked independently with a walker. She was a	A 025		

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A 025	Continued From page 9 risk due to an unsteady gait and poor balance. She did well with short distances. On she was found sitting on the floor. She was attempting to get to the bathroom without her walker. A post- investigation did not contain mobility risk criteria. On at 1:50 PM, a facility note reflected the resident had a on her left lower from a previous . She denied hitting her and was observed walking independently with the assistance of a rolling walker. An service plan indicated preventions were the same as the previously written NRA. On at 9:49 AM, a facility note reflected the resident sat on the floor in her room calling out for help. She said she lost her balance. Her walker was nearby. She had no apparent injuries. (No post- investigation) (no mobility risk criteria) On at 11:18 AM, a facility note reflected the resident she was lying on the dining room floor on her right side. She said she lost her balance. She complained of right . 911 was called and she was taken to a hospital. A post- investigation did not contain mobility risk criteria. On at 9:16 PM, she returned from the hospital. On a health care provider ordered for three visits due to 2 . An hospice note indicated she had increased and forgetfulness and her gait remained unsteady.	A 025		

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A 025	Continued From page 10 An hospice visit note indicated she was more forgetful, and her gait was unsteady. A hospice visit note indicated her gait was unsteady and she required rest periods. A hospice visit note indicated her gait was more unsteady. On at 7 PM, a facility note reflected the resident was observed lying on her right side on the floor near the of her bed with her outstretched. Her walker was next to her table. She was barefoot with night attire on. She complained of left . 911 was called and she was taken to a hospital. A hospital Computerized (CT) scan revealed an acute left and subacute of the right 11th and 12th . A mobility/ risk criteria indicated she may be at moderate to high risk for altered mobility or based on seven "yes" responses. On at 10:16 AM, the resident's adult child reported that she had a , she declined surgical repair and was told she would be unable to walk again. She was transferred from the hospital to a hospice inpatient unit. On at 2:50 AM, the resident's adult child reported that she . The facility's Prevention policy read, in part, "A post- investigation form will be completed after all that occur within the community. A resident requires completion of an updated mobility risk criteria form. Residents with a history of will have	A 025		

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A 025	Continued From page 11 interventions documented on their service plan." Class II	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo	A 032		

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A 032	Continued From page 12 identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to make a daily effort to ensure 1 of 1 sampled resident who was identified as being at risk for elopement had identification (ID) on their person that included their name and the facility's name, address, and telephone number (#6). Findings:	A 032		

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A 032	Continued From page 13 Review of resident #6's health assessment form (1823) revealed she was identified as an elopement risk. On at 10:23 AM, she was seen leaning over as if picking up something off the floor then she sat up. A bracelet device was seen on her left ankle. No ID that included her name and the facility's name, address, and telephone number was seen on her or ankles. Caregiver D said the resident wore only the bracelet device. On at 11:45 AM, the director of nursing (DON) said the resident's bracelet device was supposed to have her name on it. He then looked at it and said it did not. The resident's record revealed it did not contain documentation to indicate the facility made a daily effort to ensure she had ID on her person. Class III	A 032		