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
	AL11922279	A. BUILDING: _____ B. WING _____	05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTBROOKE GARDENS	201 SUNSET DRIVE CASSELBERRY, FL 32707

(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
CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	CZ821		

AHCA Form 3020-0001

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

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CZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	CZ821		

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CZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	CZ821		

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CZ821	Continued From page 3 to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on facility documentation, resident record review and interview, the facility failed to submit an initial adverse incident report timely electronically to the agency for 1 of 5 sampled resident (#2); and the facility failed to submit an adverse incident report to the agency for 1 of 5 sampled resident (#1) involvement of resident [redacted] by an employee (A) and requiring the local law enforcement to conduct an investigation. Findings: 1. Resident #2's record review revealed admission date [redacted]. The last 1823 Health Assessment dated [redacted] listed medical history of [redacted], recent [redacted] and [redacted]. She recently was admitted on Hospice care [redacted]. She needs assistance with all activities of daily living (ADLs) and needs assistance with self-administration of medications. A facility note dated [redacted] at 7:30 PM, the Director of Nursing (DON) documented that resident #2 was found on floor next to bed and	CZ821		

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CZ821	Continued From page 4 wheelchair in her bedroom. It was observed that a Hematoma was noted on the right side of the . . . . The family and physician notified as well has Hospice. Emergency responders transported resident #2 to hospital. A facility note dated . . . . . at 8:04 AM, the DON documented resident #2 returned to the assisted living facility from post . yesterday. A of was negative, a of abdomen and , . . scan were both completed. A new order prescribed for for a , ... The family, physician and Hospice was notified. The Hospice nurse stated will visit resident on tomorrow . . . . . . A facility note dated . . . . . at 1:57 PM, the DON documented that during morning care, it was observed that resident #2 had a . . . . on left . The family, physician and Hospice was notified. Resident #2 was sent out to hospital. A facility note dated . . . . . at 11:11 AM, the DON documented received communication from Hospice nurse that resident #2 has left . , broken and she will be having surgery and next go into skilled nursing home for rehabilitation before returning to the assisted living facility. A facility note dated at 12:44 PM, the DON documented spoke to the . . , . . from the rehab center and confirmed that resident had a left Tibula and . . . . . and will be in rehab longer. The initial (within 1 business day) report provided was not submitted on time to the agency. Resident #2's with a injury was on . . . . . , and the facility submitted the initial report to the agency on (4 days late).	CZ821		

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CZ821	Continued From page 5 (Photographic Evidence Obtained) 2. Resident #1's record reviewed revealed admission date [redacted]. The last 1823 Health Assessment dated [redacted] listed medical history of [redacted], and [redacted] with bouts of irritability. He needs assistance with [redacted], grooming, and transferring and supervision with ambulation, eating, toileting and bathing. He needs assistance with self-administration of medications. A facility incident on [redacted] at 7:37 PM involving [redacted] of terminated caregiver A and resident #1. Resident #1 was already agitated and waiting on family to visit him for his birthday ([redacted]) and grabbed a broom hitting caregiver A and caregiver A hit him [redacted]. Caregiver A slapped resident #1 hard enough to make a [redacted] on left side of his [redacted]. The local law enforcement was called, and family was notified. There was no documented evidence that the facility conducted an internal investigation; and no documented evidence of facility notes regarding this [redacted] incident occurrence on [redacted]. On [redacted] at 2:45 PM, an interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed the findings and further stated that caregiver A was suspended immediately on [redacted] and then finally terminated on [redacted]. A facility note dated [redacted] at 6:29 PM, documented by the Director of Nursing that another incident occurred involving resident #1	CZ821		

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CZ821	Continued From page 6 started to become agitated and was walking around. Staff heard resident #1 say "get out of my way" and then they turned around and saw another resident with a above his , . Department of Children and Families (DCF) was notified, and a report was filed, and it was not substantiated. The family and physician notified. There was no other supporting documented evidence of a further thorough internal investigation conducted. The facility failed to find out who was the other resident with the above the , . , who was the staff hearing resident #1 "get out of my way". In further review, the facility could not provide documentation that DCF was notified and could not provide the report file number. No documentation of the police report. On . . . . . at 2:55 PM, an interview with the Director of Nursing (DON) who confirmed that she assumed and , ... , thought that the previous Administrator notified DCF, not her and documented it as so. On . . . . . at 3:15 PM, an interview with the Business Office Manager (BOM) confirmed that caregiver A was terminated on . . . . . and could not provide any other documentation. There was no documented evidence that the incident report was electronically reported and submitted to the agency as required regarding to resident . . . . . involved by a staff (employee A) and the law enforcement conducted an investigation on . . . . . . On . . . . . at 4 PM, an interview with the DON, ADON, and the interim in training Administrator confirmed the finding.	CZ821		

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CZ821	Continued From page 7 Unclassified	CZ821		
A 000	Initial Comments Two (2) Complaint Investigations #2023003646 and #2023004232 was conducted at Gardens of Eastbrooke Assisted Living Facility and Memory Care on . . . The facility had deficiencies at the time of the survey visit.	A 000		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical	A 008		

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A 008	Continued From page 8 examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of	A 008		

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A 008	Continued From page 9 Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , , require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or , , services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of , Resistant	A 008		

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A 008	Continued From page 10 ..., ..., ..., ..., or any other communicable ..., which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, ..., which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children	A 008		

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A 008	Continued From page 11 and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or . (f) 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 the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to obtain an 1823 Health Assessment, AHCA Form that was completed entirely by the healthcare provider for 1 of 5	A 008		

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A 008	Continued From page 12 sampled residents (#3) as required. Findings: Resident #3's record review revealed an admission date of [redacted] into the secured facility. The last 1823 Health Assessment was dated [redacted] listed medical history of [redacted] and combative behavior. Furthermore, he has physical limits of [redacted] and poor judgment. He needs assistance with all his activities of daily living (ADLs) and need assistance with self-administration of medications. The 1823 Health Assessment was not completed entirely, omitting question on page 1; asking if resident was an elopement risk? That question was left unmarked. (Photographic Evidence Obtained) On [redacted] at 2:30 PM, an interview with the Director of Nursing (DON) confirmed the findings. Class III	A 008		
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 [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	A 025		

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A 025	Continued From page 13 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 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	A 025		

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	AL11922279	A. BUILDING: _____ B. WING _____	05/31/2023

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A 025	Continued From page 14 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 facility documentation, resident record review and interview, the facility failed to maintain a written record and update documentation as required for 3 of 5 sampled residents (#1, #2, #3). Findings: 1. Resident #1's record review revealed an admission date of . . . . . The last 1823 Health Assessment dated listed medical history of . . . . . and with bouts of irritability. He needs assistance with . . . . ., grooming, and transferring and supervision with ambulation, eating, toileting and bathing. He needs assistance with self-administration of medications. A facility incident on at 7:37 PM involving . . . . of terminated caregiver A and resident #1. Resident #1 was already agitated and waiting on family to visit him for his birthday ( ) and grabbed a broom hitting caregiver A and caregiver A hit him . . . . Caregiver A slapped resident #1 hard enough to make a . . . . on left side of his . . . . The local law enforcement was called, and family was notified. (Photographic Evidence Obtained) There was no documented evidence that the facility conducted an internal investigation; and no documented evidence of facility notes regarding	A 025		

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A 025	Continued From page 15 this . . . . . incident occurrence on . . . . . . On . . . . . at 2:45 PM, an interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed the findings and further stated that caregiver A was suspended immediately on . . . . . and then finally terminated on . A facility note dated at 6:29 PM, documented by the Director of Nursing that another incident occurred involving resident #1 started to become agitated and was walking around. Staff heard resident #1 say "get out of my way" and then they turned around and saw another resident with a above his , . Department of Children and Families (DCF) was notified, and a report was filed, and it was not substantiated. The family and physician notified. There was no other supporting documented evidence of a further thorough internal investigation conducted. The facility failed to find out who was the other resident with the above the , . , who was the staff hearing resident #1 "get out of my way". In further review, the facility could not provide documentation that DCF was notified and could not provide the report file number. No police report documentation provided. On at 2:55 PM, an interview with the Director of Nursing who confirmed that she assumed and , , thought that the previous Administrator notified DCF, not her and documented it as so. On at 3:15 PM, an interview with the Business Office Manager (BOM) confirmed that caregiver A was terminated on and	A 025		

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A 025	Continued From page 16 could not provide any other documentation. 2. Resident #2's record review revealed an admission date of . The last 1823 Health Assessment dated listed medical history of , recent and . She recently was admitted on Hospice care . She needs assistance with all activities of daily living (ADLs) and needs assistance with self-administration of medications. (Photographic Evidence Obtained) A facility note dated at 7:30 PM, the Director of Nursing (DON) documented that resident #2 was found on floor next to bed and wheelchair in her bedroom. It was observed that a Hematoma was noted on the right side of the . The family and physician notified as well as Hospice. Emergency responders transported resident #2 to hospital. A facility note dated at 8:04 AM, the DON documented resident #2 returned to the assisted living facility from post yesterday. A of was negative, a of abdomen and , scan were both completed. A new order prescribed for for a . The family, physician and Hospice was notified. The Hospice nurse stated will visit resident on tomorrow . A facility note dated at 1:57 PM, the DON documented that during morning care, it was observed that resident #2 had a on	A 025		

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A 025	Continued From page 17 left . . .. The family, physician and Hospice was notified. Resident #2 was sent out to hospital. A facility note dated at 11:11 AM, the DON documented received communication from Hospice nurse that resident #2 has left broken and she will be having surgery and next go into skilled nursing home for rehabilitation before returning to the assisted living facility. An initial report submitted on . . . . . that resident #2 had a with injury on . . . . . . A facility note dated . . . . . at 12:44 PM, the DON documented spoke to the , from the rehab center and confirmed that resident had a left Tibula and and will be in rehab longer. There was no facility documentation that resident #2 of discharge date from the assisted living facility to a higher level of care. The last communication by the facility to the rehab nursing home was on . . . . . . On . . . . . at 3 PM, an interview with the DON confirmed, during today's interview, that recently was informed, but was not sure of the day that resident #2 was admitted permanently into the nursing home for higher level of care and would not be returning to the assisted living facility. 3. Resident #3's record review revealed admission date . . . . . into the secured facility. The last 1823 Health Assessment dated . . . . . listed medical history of . . . . . , and combative behavior. Furthermore, he has physical limits of . . . . . and poor judgment. He needs assistance with all	A 025		

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A 025	Continued From page 18 his activities of daily living (ADLs) and need assistance with self-administration of medications. (Photographic Evidence Obtained) A facility note dated [redacted] at 3:20 PM, by the Director of Nursing (DON) documented that resident #3 was walking in the dining room, with shuffling unsteady gait and lost his balance, falling to the floor. Resident #3 was able to move his extremities within normal limits, no injuries observed and assisted [redacted] into the chair. Resident #3 began ambulating again. The physician and family were notified. Will continue to monitor. A facility note dated [redacted] at 10:52 AM, by the DON documented that , [redacted] ( ) was at the facility to assess resident #3. There was no documented evidence of the orders from the physician and no notes of when the would begin and end. There was no evidence of follow up documentation. A facility note dated [redacted] at 11:02 AM, (one month later) by the DON documented that resident #3's primary care physician (PCP) was visiting the facility today. The physician called and spoke to family about bringing low pressure stocking due to [redacted] in lower extremities. There was no documented evidence, or no facility notes with a follow up if resident #3 received the pressure stockings. A facility note dated [redacted] at 4:31 PM, by the DON documented that resident #3's physician was visiting resident #3 today and followed up.	A 025		

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A 025	Continued From page 19 The physician called to follow up with family. There was no documentation from the facility of what the physician was following up on during the . . .. visit to the facility. A facility note dated . . . . . at 4:20 PM, by the DON documented that resident #3 was found lying on floor in dining room. Resident #3 had . . . again, prior he on in the dining room. Resident #3 was sent to the hospital. The family and physician were notified. A facility note dated at 9:29 AM, by the DON documented resident #3 returned from hospital on at 1030 PM (last night). Vitals were good and normal. The . . . . on and , was negative and there were no new orders. Notified the family and physician. A facility note dated . . . . . at 8:15 AM, by the DON documented resident #3 was walking in the hallway and he lost his balance, falling to the floor. A . . . . was observed on his and . . . region. The first responders were called and transported him to hospital. The physician and family were notified. A facility note dated . . . . . at 5:12 PM by the DON documented resident #3 returned (same day) to the facility with . . . . . from the emergency room. The family and physician were notified. The facility will continue to monitor. A facility note dated . . . . . at 8:10 PM by the DON documented resident #3 was in dining room walking around, lost his balance and . again today, three hours after coming earlier from the emergency room with . . . . . to his . . . . The on the side of from earlier	A 025		

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A 025	Continued From page 20 reopened. The first responders were called again, and he was sent to the hospital. The family and physician were notified. A facility note dated [redacted] at 1:30 PM by the DON documented spoke to nurse at the nursing home rehabilitation center and she informed that resident #3 was alert. He was participating in his [redacted], took his medications crushed, and ate his breakfast with encouragement. On [redacted] at 3:40 AM, an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) confirmed the findings. The DON further stated that she agreed that the documentation needs improvement. It was explained that all documentation must tell a story of the resident and have a timeline to ensure that appropriate supervision and interventions was given. Class III	A 025		