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
	AL11969314	A. BUILDING: _____ B. WING _____	06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HSRE-ASL CASSELBERRY TRS LLC	2701 HOWELL BRANCH RD WINTER PARK, FL 32792

(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 complaint investigation #2023004993 was conducted at Allegro Winter Park on . . . . . The facility had a 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 59A-36.012, F.A.C.	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
	AL11969314	A. BUILDING: _____ B. WING _____	06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HSRE-ASL CASSELBERRY TRS LLC	2701 HOWELL BRANCH RD WINTER PARK, FL 32792

(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 (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 5 sampled residents (#3 and #4). Findings: A record review for resident #4 revealed a facility admission date of . A health assessment form (1823) indicated a history of and was not identified as a risk.	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
	AL11969314	A. BUILDING: _____ B. WING _____	06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HSRE-ASL CASSELBERRY TRS LLC	2701 HOWELL BRANCH RD WINTER PARK, FL 32792

(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 A facility note on . . . . . at 11:48pm read, "During rounds staff observed this resident on the floor. This resident sock was a potential causative of the findings. Spoke with son Peter via phone. He asks to ensure the . . . shift don't let this resident go to bed with her socks on going forward". A facility note on . . . . . at 7:16am read, "This writer was summoned to this resident's room at 7:10am. Upon arrival this resident was found on the floor. This resident indicated that she tried to go to the bathroom and lost her balance because of slippery sock". A facility note on at 2:55pm read, "Resident . onto her right side on the ground". The three Risk Evaluation forms provided indicated that "If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential ". The dates and scores resident #4 were on . . . . - score 11, ... - score 12, and - score 12. On at 4pm the Resident Service Director stated, "we just do checks on all of them. That's just what we do". "We only have 2 staff, and they can't check on everyone. Other than us doing frequent checks that's all we can. We can't do every hour or every 15 minutes". There was no documentation for . interventions for Resident #4's . Review of resident #3's record revealed a facility admission date of . . . . . Her medical history included mild , , gait/mobility,	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
	AL11969314	A. BUILDING: _____ B. WING _____	06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HSRE-ASL CASSELBERRY TRS LLC	2701 HOWELL BRANCH RD WINTER PARK, FL 32792

(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 and risk for . . A . . . . . 1823 health assessment form indicated she was independent with ambulation, toileting, and transferring and required supervision with bathing, _, and grooming. She resided on the facility's memory care unit. On at 4:58 pm she was found sitting on her . . . . . on the floor leaning against her bed. On . . . . . at 10:30 pm she was found sitting on the floor of her apartment while staff was doing rounds. She told staff she put herself on the floor and did not . On she scored 8 on a risk evaluation. On . . at 10:16 am staff reported she was leaning to the right. When assessed by a facility nurse, she was leaning while sitting in a dining room chair. Her grips were equal, and her smile was even. She was able to transfer to a wheelchair with some assistance and she was fully alert and able to speak without difficulty. A health care provider was notified and decided to just watch her. On . . . . . at 6:36 pm she . onto her left side while in her bedroom. She said she had just gotten out of the bathroom. On . . . . . at 7:04 pm she appeared weak, leaning to her right side and drooling. A Covid test was positive. On . . . . . at 5:09 pm she was found sitting on her room floor in front of her chair. She said she slid out of the chair. She was weak and had a runny .	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969314	A. BUILDING: _____ B. WING _____	06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HSRE-ASL CASSELBERRY TRS LLC	2701 HOWELL BRANCH RD WINTER PARK, FL 32792

(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 4 On at 7:09 pm she was observed laying on her left side on the floor. She said she was coming out of the bathroom and . Her right area was . On at 10:29 pm she continued on isolation due to positive Covid. She was very weak, and her appetite was poor. Frequent checks to maintain safety. On at 8:53 pm safety checks were done by staff. On at 7:45 am she attempted to sit in a dining room chair and tripped over her walker and . She sustained a on her left . On she scored 10 on a risk evaluation. On a health care provider ordered physical and occupational therapies for recurrent , recent Covid 19, and . On at 9:51 pm she was observed drooling and leaning to the right at dinner and very thereafter. She was looking for her car to go visit her parents. She was also looking for a little boy. A Covid test was done and was negative. The nurse will follow up with the resident to see if continues before doctor informed. On at 12:04 pm staff found her laying in front of her chair in her bedroom. She was unable to say what happened. Staff observed a large amount of coming from the of her . Pressure was applied. 911 was called and she was taken to a hospital.	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969314	A. BUILDING: _____ B. WING _____	06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HSRE-ASL CASSELBERRY TRS LLC	2701 HOWELL BRANCH RD WINTER PARK, FL 32792

(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 5 On at 4:23 pm a report received from the hospital revealed she received two staples and two on the of her . A hospital after visit summary indicated the reason for her visit was a with a of her , , blunt injury. On at 5 pm she returned from the hospital. On she scored 11 on a risk evaluation. On at approximately 7:20 am she was found on the floor alongside her bed. She had on top of her from a previous . She complained of . 911 was called and she was taken to a hospital. On at 1:15 pm she returned from the hospital. Frequent checks were conducted on her. A hospital after visit summary indicated she was seen for a with a injury. On at 2:50 pm she was very unsteady on her that morning and had a difficult time using her walker. She was assisted into a wheelchair and to breakfast. She wanted to use her walker after lunch, so staff provided stand-by assistance while she did. Staff provided frequent checks to ensure her safety and assist with care as needed. On a health care provider ordered a manual wheelchair for recurrent , ,	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969314	A. BUILDING: _____ B. WING _____	06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HSRE-ASL CASSELBERRY TRS LLC	2701 HOWELL BRANCH RD WINTER PARK, FL 32792

(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 6 On at 2:35 pm she ambulated on the unit with a walker. Staff provided frequent checks and assisted her with care as needed. On at 2 pm staff observed her sitting on the floor. She was unable to state what happened. On at 3:25 pm she attempted to sit in a dining room chair and onto her right side. On at 12:07 pm staff found her sitting on her on the floor in her room. Will continue to observe. On she scored 12 on a risk evaluation. On at 9:48 am staff found her sitting on the floor next to her bed. She stated she in the bathroom then crawled to her bed. Her walker was in her bathroom. On she scored 12 on a risk evaluation. On she scored 10 on a risk evaluation. During an interview with the resident's niece-in-law on at 11:47 am, she said regarding the "we are very happy with the Allegro. They have called me anytime she's ". She felt the facility staff provided the resident with adequate supervision and said the resident was hard-headed. On at 3:25 pm, the resident was seen laying in her bed. Her walker was next to the bed.	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
	AL11969314	A. BUILDING: _____ B. WING _____	06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HSRE-ASL CASSELBERRY TRS LLC	2701 HOWELL BRANCH RD WINTER PARK, FL 32792

(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 7 The facility's minimizing risk policy read, in part, a resident identified as being at risk for will have approaches developed and implemented to attempt to minimize the risk to the resident of and injury. Further, these approaches will be documented in the resident record and on the resident care/service plan. A investigation form will be completed and approved by the resident service director and the executive director. The form will outline the findings and steps that need to be taken to attempt to proactively decrease the resident potential. Class III	A 025		