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
	AL11968966	A. BUILDING: _____ B. WING _____	07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTRY PARK ORLANDO	3201 CENTER POINT DR ORLANDO, FL 32825

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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		

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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 record reviews and interviews, the facility failed to electronically submit information requested by the agency for 3 of 3 sampled residents (#6, #7, #8). Findings: Review of the facility's incident reports submitted to the agency revealed the following: On the agency accepted a preliminary report regarding resident #6 eloping from the facility on . On the agency administratively closed the report because requested information was not received from the facility. On the agency accepted a preliminary report regarding resident #7 being sent to a hospital and an incident that was reported to law enforcement to conduct an investigation on . On the agency administratively closed the report because requested information was not received from the facility. On the agency requested additional information after reviewing a preliminary report	CZ821		

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CZ821	Continued From page 4 regarding resident #8 being sent to a hospital on . On the agency administratively closed the report because requested information was not received from the facility. During an interview on at 1:05 pm, the assistant administrator said the wellness director was responsible for submitting the reports. She then said she had no idea the agency requested more information. During an interview on at 1:15 pm, the assistant administrator said she reviewed the reports online and saw where the reports were administratively closed. During an interview on at 3:56 pm, the wellness director said she was responsible for submitting the reports. She said she did receive agency requests for additional information but, after submitting additional information there was still a message that informatin was needed. She said she never contacted the agency for assistance. Unclassified	CZ821		
A 000	Initial Comments A complaint investigation #2023006845 was conducted at Gentry Park Orlando on . The facility had deficiencies at the time of the survey.	A 000		
A 030 SS=G	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY	A 030		

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A 030	Continued From page 5 PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida . . . . Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. . . . . and tobacco use; 3. Medication storage; 4. Resident elopement;	A 030		

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A 030	Continued From page 6 5. Reporting resident . . . . . , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect.	A 030		

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A 030	Continued From page 7 (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any	A 030		

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A 030	Continued From page 8 resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall	A 030		

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A 030	Continued From page 9 establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits;	A 030		

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A 030	Continued From page 10 choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [illegible] or [illegible] under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to honor resident rights by failing to maintain a safe living environment, free from resident to resident [illegible] for 2 of 2 sampled residents (#7 and #8). Findings: 1. Review of resident #7's record revealed a facility admission date of [illegible]. A [illegible] 1823 health assessment indicated her medical history included moderate to severe [illegible]. It indicated she needed 24/7 supervision, had a history of agitation, was a [illegible] risk and her needs could be met in an assisted living facility. A facility evaluation indicated the resident was oriented to person, place, time and situation. She had requiring additional attention. She [illegible] during sleep hours between am, gathered and placed items	A 030		

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A 030	Continued From page 11 inappropriately, refused meds and oftentimes refused meals. It indicated she had a history of behavioral expression or inappropriate behaviors related to , a - , , illness, . A service plan goal was that she would not be disruptive to other residents, families or staff through next review, which was . A 1:25 pm facility note indicated she alternated between being aggressive and weepy. Attempts to redirect her were inconsistently effective. On a health care provider ordered (used to treat) and (, and episodes) and). A 10 am facility note indicated she hit another resident on the . The other resident was not injured. During an interview on at 2:06 pm, the wellness director said the other resident was resident #8. A 9:32 am facility note indicated she refused her medications. She did not believe her doctor prescribed it and even after examining the bottle, she would not take them. A 12:32 pm facility note indicated she put her on another resident's (resident #8 again). Neither resident was injured. Due to the incident, resident #7 was sent to the hospital. During an interview on at 2:20 pm, the wellness director said resident #7 was to a hospital. A 7:46 pm facility note indicated she	A 030		

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A 030	Continued From page 12 returned from the hospital. A . . . . 4 pm facility note indicated she was observed in the common area frantically moving the furniture and electric fireplace. The fireplace was removed from the wall with wires and connected. The nurse approached her and the resident was speaking in a low tone and holding a hair brush in her . . . The nurse attempted to redirect her and she began to hit the nurse with the brush. She continued to move the fireplace forward, which was noted to be a hazard. The nurse stood in front of the fireplace to stop it from being moved. 911 was called. Another resident (resident #8 again) said resident #12 pushed her into the wall where she into it and hit her . . . Resident #8, who was later sent to the hospital, was observed on the floor with a small amount of . . . on the . . . of her . . and the floor. Resident #12 was escorted out of the facility by police and while doing so, the resident approached another resident in the assisted living cafe and took the resident's walker. When emergency personnel arrived she sat on a gurney but refused to wear the safety belts on her . . and across her . She agreed to wear the one across her waist and hung her . . over the side of the gurney. She would not cooperate so she was encouraged to ride in the police car and again she would not cooperate. Fire rescue arrived and spoke with her about her options for transport. She would not cooperate and was eventually picked up and placed on the gurney by emergency personnel. She was hitting and scratching them while they fastened the safety belts. She was transported to a hospital. Her family was notified and informed the resident could not return to the facility. 2. Review of resident #8's record revealed a	A 030		

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A 030	Continued From page 13 facility admission date of . . . . Her medical history included , , , and . . . . She ambulated independently with a walker. A 6:12 pm facility note indicated she was observed laying on her . . . in the dining room near the door. She was holding the of her . . . . and . . . . was on her . . . She complained of , to the of her when staff attempted to assist her off the floor. The resident said she was walking around with her walker when she passed another resident (resident #7), who she told that she did something wrong. It was then the other resident pushed her against the wall. The incident was unwitnessed by staff. When assisted off the floor she yelled in , and said her hurt. 911 was called and she was taken to a hospital. A . . . . . 7:50 am facility note indicated she returned from the hospital. , and a were all negative. A . . . . . 7:32 pm facility note indicated she yelled out in , when attempting to transfer from her bed to a wheelchair. Her family visited and took her outside for a walk, which she tolerated. She was given . . . . , . and a health care provider was contacted for a stronger , . medication. A . . . . . 11:15 am facility note indicated she continued to complain of severe , . It was very difficult to roll and change her in bed because of it. Her health care provider did not want to increase her , . medications due to a risk for . On a health care provider ordered	A 030		

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	AL11968966	A. BUILDING: _____ B. WING _____	07/17/2023

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A 030	Continued From page 14 . . . . . patch and . . . . for . . . During an interview on . . . . . at 1:55 pm, resident #8 did not remember having problems with resident #7. During an interview on . . . . . at 1:56 pm, the memory care director said resident #7's . . would drastically change. She said the resident would be talkative, not so friendly then friendly. She said the resident had incidents in which she became agitated with staff and other residents. She said staff tried to get the resident involved with activities but she'd stay only a minute or two. She said the resident enjoyed books so staff provided her with books from the facility's library. During an interview on at 2:20 pm, the wellness director said she educated staff on redirecting resident #7. She said when the resident was admitted to the facility she did not have medications ordered and it took a while to get her enrolled with a facility health care provider. During an interview on at 3:42 pm, caregiver C said resident #7 was very aggressive with staff and other residents. She then said "we had to be watching her all the time. I couldn't control her. One time she me and the other lady was on break. I had to call her on the radio". During an interview on at 3:48, caregiver D said resident #7 was aggressive towards staff and residents. During an interview on at 4:36 pm, the assistant administrator said that when resident #7 first came to the facility she had a history of	A 030		

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A 030	Continued From page 15 . . . and did not exhibit behaviors at that time. She said that although resident #8 said resident #7 slapped her . . . . . , it was not witnessed by staff. She recalled something about resident #7's family coming to be with her. She thought it was after and they stayed with the resident 24 hours each day for . . days. She said resident #7's family also took her home with them somethings. The facility's . . . . . , neglect, ... policy defined . . . as an act or failure to act, either intentional or reckless, which causes or is likely to cause physical or emotional harm to a resident. . . . . can be either physical, emotional, or verbal. Class II	A 030		

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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		

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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 record reviews and interviews, the facility failed to electronically submit information requested by the agency for 3 of 3 sampled residents (#6, #7, #8). Findings: Review of the facility's incident reports submitted to the agency revealed the following: On the agency accepted a preliminary report regarding resident #6 eloping from the facility on . On the agency administratively closed the report because requested information was not received from the facility. On . . . . . the agency accepted a preliminary report regarding resident #7 being sent to a hospital and an incident that was reported to law enforcement to conduct an investigation on . . . . . On . . . . . the agency administratively closed the report because requested information was not received from the facility. On the agency requested additional information after reviewing a preliminary report	CZ821		

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CZ821	Continued From page 4 regarding resident #8 being sent to a hospital on . On the agency administratively closed the report because requested information was not received from the facility. During an interview on at 1:05 pm, the assistant administrator said the wellness director was responsible for submitting the reports. She then said she had no idea the agency requested more information. During an interview on at 1:15 pm, the assistant administrator said she reviewed the reports online and saw where the reports were administratively closed. During an interview on at 3:56 pm, the wellness director said she was responsible for submitting the reports. She said she did receive agency requests for additional information but, after submitting additional information there was still a message that informatin was needed. She said she never contacted the agency for assistance. Unclassified	CZ821		
A 000	Initial Comments A complaint investigation #2023006845 was conducted at Gentry Park Orlando on . The facility had deficiencies at the time of the survey.	A 000		
A 030 SS=G	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY	A 030		

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A 030	Continued From page 5 PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida . . . . Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. . . . . and tobacco use; 3. Medication storage; 4. Resident elopement;	A 030		

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A 030	Continued From page 6 5. Reporting resident . . . . . , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect.	A 030		

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A 030	Continued From page 7 (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any	A 030		

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A 030	Continued From page 8 resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall	A 030		

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A 030	Continued From page 9 establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits;	A 030		

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A 030	Continued From page 10 choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [illegible] or [illegible] under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to honor resident rights by failing to maintain a safe living environment, free from resident to resident [illegible] for 2 of 2 sampled residents (#7 and #8). Findings: 1. Review of resident #7's record revealed a facility admission date of [illegible] A [illegible] 1823 health assessment indicated her medical history included moderate to severe [illegible]. It indicated she needed 24/7 supervision, had a history of agitation, was a [illegible] risk and her needs could be met in an assisted living facility. A facility evaluation indicated the resident was oriented to person, place, time and situation. She had requiring additional attention. She [illegible] during sleep hours between am, gathered and placed items	A 030		

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(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 030	Continued From page 11 inappropriately, refused meds and oftentimes refused meals. It indicated she had a history of behavioral expression or inappropriate behaviors related to , a - , , illness, . A service plan goal was that she would not be disruptive to other residents, families or staff through next review, which was . A 1:25 pm facility note indicated she alternated between being aggressive and weepy. Attempts to redirect her were inconsistently effective. On a health care provider ordered (used to treat) and (, and episodes) and). A 10 am facility note indicated she hit another resident on the . The other resident was not injured. During an interview on at 2:06 pm, the wellness director said the other resident was resident #8. A 9:32 am facility note indicated she refused her medications. She did not believe her doctor prescribed it and even after examining the bottle, she would not take them. A 12:32 pm facility note indicated she put her on another resident's (resident #8 again). Neither resident was injured. Due to the incident, resident #7 was sent to the hospital. During an interview on at 2:20 pm, the wellness director said resident #7 was to a hospital. A 7:46 pm facility note indicated she	A 030		

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	AL11968966	A. BUILDING: _____ B. WING _____	07/17/2023

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A 030	Continued From page 12 returned from the hospital. A . . . . 4 pm facility note indicated she was observed in the common area frantically moving the furniture and electric fireplace. The fireplace was removed from the wall with wires and connected. The nurse approached her and the resident was speaking in a low tone and holding a hair brush in her . . . The nurse attempted to redirect her and she began to hit the nurse with the brush. She continued to move the fireplace forward, which was noted to be a hazard. The nurse stood in front of the fireplace to stop it from being moved. 911 was called. Another resident (resident #8 again) said resident #12 pushed her into the wall where she into it and hit her . . . Resident #8, who was later sent to the hospital, was observed on the floor with a small amount of . . . on the . . . of her . . and the floor. Resident #12 was escorted out of the facility by police and while doing so, the resident approached another resident in the assisted living cafe and took the resident's walker. When emergency personnel arrived she sat on a gurney but refused to wear the safety belts on her . . and across her . She agreed to wear the one across her waist and hung her . . over the side of the gurney. She would not cooperate so she was encouraged to ride in the police car and again she would not cooperate. Fire rescue arrived and spoke with her about her options for transport. She would not cooperate and was eventually picked up and placed on the gurney by emergency personnel. She was hitting and scratching them while they fastened the safety belts. She was transported to a hospital. Her family was notified and informed the resident could not return to the facility. 2. Review of resident #8's record revealed a	A 030		

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A 030	Continued From page 13 facility admission date of . . . . Her medical history included , , , and . . . . . She ambulated independently with a walker. A 6:12 pm facility note indicated she was observed laying on her . . . in the dining room near the door. She was holding the of her . . . . and . . . . was on her . . . She complained of , to the of her when staff attempted to assist her off the floor. The resident said she was walking around with her walker when she passed another resident (resident #7), who she told that she did something wrong. It was then the other resident pushed her against the wall. The incident was unwitnessed by staff. When assisted off the floor she yelled in , and said her hurt. 911 was called and she was taken to a hospital. A . . . . . 7:50 am facility note indicated she returned from the hospital. , and a were all negative. A . . . . . 7:32 pm facility note indicated she yelled out in , when attempting to transfer from her bed to a wheelchair. Her family visited and took her outside for a walk, which she tolerated. She was given . . . . , . and a health care provider was contacted for a stronger , . medication. A . . . . . 11:15 am facility note indicated she continued to complain of severe , . It was very difficult to roll and change her in bed because of it. Her health care provider did not want to increase her , . medications due to a risk for . On a health care provider ordered	A 030		

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A 030	Continued From page 14 . . . . . patch and . . . . for . . . During an interview on . . . . . at 1:55 pm, resident #8 did not remember having problems with resident #7. During an interview on . . . . . at 1:56 pm, the memory care director said resident #7's . . would drastically change. She said the resident would be talkative, not so friendly then friendly. She said the resident had incidents in which she became agitated with staff and other residents. She said staff tried to get the resident involved with activities but she'd stay only a minute or two. She said the resident enjoyed books so staff provided her with books from the facility's library. During an interview on at 2:20 pm, the wellness director said she educated staff on redirecting resident #7. She said when the resident was admitted to the facility she did not have medications ordered and it took a while to get her enrolled with a facility health care provider. During an interview on at 3:42 pm, caregiver C said resident #7 was very aggressive with staff and other residents. She then said "we had to be watching her all the time. I couldn't control her. One time she me and the other lady was on break. I had to call her on the radio". During an interview on at 3:48, caregiver D said resident #7 was aggressive towards staff and residents. During an interview on at 4:36 pm, the assistant administrator said that when resident #7 first came to the facility she had a history of	A 030		

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A 030	Continued From page 15 [redacted] and did not exhibit behaviors at that time. She said that although resident #8 said resident #7 slapped her [redacted], it was not witnessed by staff. She recalled something about resident #7's family coming to be with her. She thought it was after [redacted] and they stayed with the resident 24 hours each day for [redacted] days. She said resident #7's family also took her home with them somethings. The facility's [redacted], neglect, [redacted] policy defined [redacted] as an act or failure to act, either intentional or reckless, which causes or is likely to cause physical or emotional harm to a resident. [redacted] can be either physical, emotional, or verbal. Class II	A 030		