

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/10/2023
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PALMETTO LANDING

**1016 WILLA SPRINGS DRIVE
WINTER SPRINGS, FL 32708**

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A 000	Initial Comments A re-licensure survey and a generator monitoring was conducted at Palmetto Landing Assisted Living Facility & Memory Care on . The provider had deficiencies at the time of the visit.	A 000		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2) (a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary.	A 032		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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NAME OF PROVIDER OR SUPPLIER PALMETTO LANDING			STREET ADDRESS, CITY, STATE, ZIP CODE 1016 WILLA SPRINGS DRIVE WINTER SPRINGS, FL 32708		
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A 032	Continued From page 1 The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure and have documentation to indicate 2 of 4 sampled staff participated in a minimum of two resident elopement drills each year (C and administrator). Findings: Review of caregiver C's personnel record	A 032			

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A 032	Continued From page 2 revealed a hire date of Review of the administrator's personnel record revealed a hire date of During an interview with caregiver C on at 10 am, she was asked if she participated in resident elopement drills and if so, how many. Despite being asked in different ways to help her understand the question, she did not know what a resident elopement drill was. Review of the facility's documented 2022 elopement drills revealed they were conducted on and Caregiver C was listed as a participant on however, she was not hired until The administrator was not listed as a participant on any of them. On at 1:40 pm, the administrator said she participated in the drills conducted on and and just did not sign the forms. On at 1:50 pm, the administrator said she could not explain how caregiver C was listed on the drill when she was not employed. Class III	A 032			
A 034 SS=D	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for	A 034			

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A 034	Continued From page 3 assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 1 of 5 sampled resident's use of a bed rail was documented in the resident's record (#11). Findings: On _____ at 9:28 am, one half-siderail was seen on resident #11's bed. Review of the resident's record revealed it did not contain documentation of her use of the siderail, which is an assistive device. On _____ at 1:59 pm, the administrator said she was unable to provide the required documentation. On _____ at 2:12 pm, the resident said she used the rail to get in and out of bed. Class III	A 034		

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A 052 SS=D	429.256(); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the	A 052		

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A 052	Continued From page 5 prescribed premeasured dose of medication into the dispensing cup of the (4) Assistance with self-administration of medication does not include: (a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a _____ of the body. (d) Administration of _____ preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with _____, or _____ preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008	A 052		

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A 052	Continued From page 6 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be 18 years of age or older, trained to assist with self-administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the	A 052		

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A 052	Continued From page 7 resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's _____ control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to arrange for 1 of 5 sampled residents to take their medication while away from the facility and from facility staff (#11). Findings: Review of resident #11's _____ and 1823's revealed they both indicated she required assistance with self-administration of medications. Her medical diagnoses included _____'s _____. Review of her _____, _____, _____, and _____.	A 052		

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A 052	Continued From page 8 2023 medication observation records (MORs) revealed "03" (absent from home) was charted for the 2 pm dose of _____ on _____, all of which were a Thursday. On _____ at 2:12 pm, resident #11 said she goes to a doctor's _____ every Thursday and returns around noon. She then said a family member transports her to the _____. The facility's undated Transferring medications for home visits or outings policy indicated, among other things, that when a resident leaves the community for a short period of time during which only one dose of medication is needed, the designated associate person gives the medication to a responsible party in an envelope, or similar container, labeled with the resident's name, name of the medication, and instructions for administering the dose. On _____ at 3 pm, med tech A said resident #11 was not given her 2 pm dose of medication on Thursdays because she was at an _____. The health and wellness director then said the resident's medication was not sent with her to the _____. On _____ at 3:30 pm, the administrator said the reason the resident's medication was not sent with her was because her family did not tell the med tech when they were leaving. A discussion was had with the administrator regarding the facility's responsibility to follow its policy and to discuss with the resident's family the options available to ensure the resident did not miss a dose of her medication. Class III	A 052		

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