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
	AL11967569	A. BUILDING: _____ B. WING _____	C 06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF TITUSVILLE	497 N WASHINGTON AVE TITUSVILLE, FL 32796

(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 #2022017891 and #2023001295 was conducted at Addington Place of Titusville on . The facility had a deficiency at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on 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 1 of 4 sampled residents (#3). Findings: Review of resident #3's record revealed a facility admission date of . Her medical history included early mild , , short term memory and poor balance. An 1823 health assessment form indicated	A 025		

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A 025	Continued From page 2 she was independent with bathing, , grooming, toileting, ambulation and transferring at that time. A facility evaluation indicated she had no history of . On at 5:10 pm she went to a health care provider who specialized in memory care. She had in her at the . The health care provider thought the resident was having a mini and believed it was safe for her to live at the facility. On at 7:30 am she was yelling and was found lying on her in her room. She said she out of bed and rolled onto her arm. She sustained a and on her left and complained of left . Her daughter came to the facility and took her to a hospital. She returned to the facility with a diagnosis of injury of left , of left and a on her left . Her left arm was in a sling with directions that she may remove it at bedtime and to follow-up with an Orthopedic. Frequent checks put in place. (The frequency was not specified, there was no further investigation to the causative reasons/contributing factors, no additional documentation of post- interventions and the incident report also did not list interventions) On at 3:26 pm her daughter took her to an orthopedic . The doctor did not want her doing , ( ) at that time. On at 11:32 pm she called for help and was found on the floor next to her bed. She did not know what happened but did say she hit her and had . Her daughter was	A 025		

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A 025	Continued From page 3 notified and refused for 911 to be called. (There was no further investigation to the causative reasons/contributing factors, no additional documentation of post- interventions and the incident report also did not list interventions) On . . . . . at 5:17 pm she was found lying on her in the bathroom. She said she landed hard and thought she broke her left , and wanted to go to the hospital. She was sent to a hospital via 911. (There was no further investigation to the causative/reasons/contributing factors, no additional documentation of post- interventions and the incident report also did not list interventions) On at 10:01 pm she was admitted to the hospital with a left , ... On . . . . . at 1:40 pm, a request was made of the administrator to provide any additional related documentation for the resident. On . . . . . at 3:10 pm, caregiver E said to decrease the risk of residents falling she conducted every two-hour checks and provided them with toileting and care. She said if they were considered a . . risk, she checked on them more frequently and kept them engaged with activities. She said if a resident . , she immediately contacted a nurse and waited for them to arrive to the location. She thought maybe she was trained on when she was first hired. She provided resident service plans located in a cabinet on the unit which identified residents who were considered a . risk. On at 3:20 pm, caregiver D said he received . related training via an online	A 025		

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A 025	Continued From page 4	A 025		

program. He said for residents who were at risk for he toileted them every two hours and closely watched them.

On at 3:27 pm, caregiver C said she would call a nurse if a resident and would check to see if the resident was okay. She said she received training but did not remember when. She said she checked on the residents every two hours and more often for those who wore briefs. She could not recall if there was a service plan binder and said maybe the nurse had it.

On at 3:38 pm, caregiver F said there was a book for every resident in which the staff documented . She said she is receiving training on and was aware of the policy. When a resident , she usually called a nurse. If a nurse was unavailable, she asked the resident if they could move and if not, she called for lift assistance. To ensure a resident's safety she said "we make sure they don't . If a resident is a risk, we always watch and keep them out in the common areas so we can watch them".

On at 4:20 pm, the director of nursing said she provided all the documentation that was available for the resident, including additional prevention documentation.

The facility's management program guideline read, in part, all must be investigated to the causative reasons/contributing factors. All care staff will be responsible in assisting with the implementation of the community's management program to maintain the safety of all residents in the community. The program will include measures which determine the individual needs of each

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A 025	Continued From page 5 resident by evaluating the risk of and implementation of appropriate interventions to provide necessary supervision and assistive devices as necessary. All staff will be trained on the prevention program upon hire. Review of caregiver C's, D's, E's, and F's personnel records revealed no documentation to indicate any of them received training on the facility's prevention program. Class II	A 025		