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
	AL11964204	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD PLACE	2680 CROTON ROAD MELBOURNE, FL 32935

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A 000	Initial Comments A re-licensure survey, Generator monitoring and complaint investigation #2022014023 was conducted at Greenwood Place Assisted Living Facility on . . . . . The facility had a deficiency at the time of the visit.	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	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 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 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 resident record review and interview, the facility failed to provide adequate supervision and failed to provide care and services appropriate to meet the needs to ensure safety through proactive measures to minimize the potential for and injuries for 4 of 6 sampled residents who experienced repeated (# #2, #3, #17); and the facility's policies did not have procedures defining interventions that would be put in place for all at risk residents and completing risk assessments. Findings:	A 025		

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A 025	Continued From page 2 1. Resident #1's record review revealed admission date . . . . . The last 1823 Health Assessment dated listed medical history of . . . . . , ... , ... , non-lymphoma, and . . . obstruction. His physical limitations were generalized and . . . status forgetful and . . . . . He needs assistance with activities of daily living (ADLs) with bathing, ... and grooming. Supervision with ambulation and transferring. Independent with eating and toileting. Needs assistance with self-administration of medications. A facility note dated (late entry) at 7:20 AM by the Director of Nursing (DON) documented resident #1 was in lobby and it was observed that his left arm was . . . Resident #1 stated he . . in his room about an hour before but did not alert anyone. Resident #1 had a above left . . . , and he stated it hurts. Resident #1 had difficulty raising his left arm and his upper arm had scratches and . . . . . It was observed that a glass floor lamp was broken when he First aid applied and family, physician was notified of incident via voicemail. A facility note dated at 9:40 AM by nurse F documented resident #1 complaining of , in left after his this morning. Physician notified and orders , of left . Notified family. A facility note dated at 8:26 PM by nurse F documented resident #1 has complained of left ankle , after he had a this morning. Notified physician and asked for , of left ankle 2 view; placed a call to Mobilex portable , and	A 025		

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A 025	Continued From page 3 they will come out tomorrow. Family notified. There was no documentation of intervention or no follow up orders for home health therapies that shows the facility put in place and the facility did not complete a risk assessment after this . A facility note dated at 12:58 PM by the Administrator documented resident #1 was sitting on his walker while trying to move across the activity room. While attempting to do so resident #1 backwards to the floor. Resident #1 stated he hit his on the floor. Resident #1 was complaining of , , and , . 911 was called and he was transported to the hospital. A facility note dated at 1:20 PM by the DON documented called the hospital for an update on resident. The resident will be returning around 2 PM today. Spoke with nurse at the hospital stating there were no injuries from resident #1's . A facility note dated at 11:38 AM by nurse F documented at approximately 7:45 AM resident #1 was observed sitting in the hallway, in front of his room door wearing shirt, pants and shoes. Resident #1 stated that he hit his . Called 911 at 7:47 AM, First responders and emergency transport arrived at facility at 7:50 AM. Resident #1 left community at 8AM. A facility note dated at 11:51 AM by nurse F documented received call from the hospital at approximately 10:37 AM confirming that resident #1 has a on his 5 ( ). Notified the physician and family of the and waiting for new orders.	A 025		

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A 025	Continued From page 4 A facility note dated at 3PM by DON documented resident had a on . Resident #1 was sent to the hospital via emergency transport. A performed {sic performed} at the hospital but before results were given the hospital sent her {sic him} home (facility). Resident #1 returned to the assisted living facility prior to obtaining results of the from the hospital. The hospital requested resident #1 to be sent for admission per orthopedic doctor due to a L5 (/) . Family requested resident #1 not to return to that hospital but instead send him to another local hospital. Resident #1 is still currently out of the facility. (Photographic Evidence Obtained) 2. Resident #2's record review revealed admission date . The last 1823 Health Assessment dated listed the medical history of , Leukopenia, and . He is a risk and ambulates with a walker and wheelchair. He needs assistance with activities of daily living (ADLs) with ambulation and grooming. Supervision with bathing, , toileting, and transferring. Independent with eating. He needs assistance with self-administration of medications. A facility note dated (late entry) at 8:35 AM by the DON documented received a call from emergency room nurse from hospital advising resident #2 was being admitted into the hospital due to a to his and . Spoke with case manager confirmed resident #2 had a and faxed over results. The case manager also stated that resident #2 was waiting	A 025		

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A 025	Continued From page 5 for orthopedic surgeon consult and [illegible] to clear him for surgery, then he will be transferred to rehab post-surgery. A facility note dated [illegible] at 3:53 PM by the DON documented resident #2 had a [illegible] with injuries on [illegible]. Action: resident #2 was sent to hospital and the hospital notified the family that resident #2 had a break in his [illegible] and [illegible]. Response: resident #2 will be having surgery [illegible]. Resident #2 will then be going to rehabilitation for [illegible] and recovery from surgery. Will follow up with resident #2 while at rehab. (Photographic Evidence Obtained) 3. Resident #17's record review revealed admission date [illegible]. The last 1823 Health Assessment dated [illegible] listed the medical history of [illegible] and a [illegible]. His [illegible] status is [illegible]. He needs assistance with activities of daily living (ADLs) with bathing, grooming and toileting. Supervision with ambulation, [illegible] and transferring. Independent in eating. He needs assistance with self-administration of medications. A facility note dated [illegible] at 5:02 AM by Med Tech G documented resident #17 was found at bottom of stairwell, semi-[illegible] and he said he [illegible] down 3 to 4 steps. Resident #17 stated he was waiting for transportation [illegible] to the emergency room for evaluation of obstruction but left his room and went downstairs with his walker. A facility note dated [illegible] at 11:48 AM by nurse H documented getting resident #17 ready for lunch and a safety check, observed resident	A 025		

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A	Continued From page 6 #17 on the floor at the . . . of his bed. Asked what happened and resident #17 verbalized he was sleeping on the floor. Resident #17 was alert but showing signs of . No new open areas or no . . . . . observed. Resident #17 stated he did not hit his . . Vitals checked. Resident #17 stated that 0 out of 10 for , at the moment. Notified daughter and the physician. A facility note dated at 6:45 PM by nurse F documented resident #17 was sitting in the doorway of bathroom wearing shirt and underwear with socks on in his room. Resident #17 stated he was trying to go to the bathroom. Resident #17 had no . . . . or . . . . . . Resident #17 had no complaints of , or discomfort. The family was notified. A facility note dated . . . . at 9:37 AM by the DON documented resident #17 had a on . . . . . No injuries. Resident #17 was educated on use of his walker while up ambulating. A facility note dated at 11:09 AM by nurse F documented resident #17 will be having surgery on for the and will be coming . . . to the facility with a . . . . . in place and will need , , reported by the daughter. There was no facility documentation about the outcome of resident #17's surgery and when resident #17 returned . . . to the facility with no orders for the care and additional therapies needed from home health agency. A facility note dated . . . . . at 1:04PM by the DON documented resident #17 had a on . . . . . Transported to hospital via emergency transportation for further evaluation. Resident #17	A 025		

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A 025	Continued From page 7 reported hitting his . . . . . The hospital completed a , and everything came negative. Resident #17 returned to the community. Resident #17 is currently , , , , services. There was no facility documentation or no home health documentation for progress of , , , , , and . . . . . care available. (Photographic Evidence Obtained) On . . . . . at 4:46 PM, an interview with the DON regarding the for resident #1, #2 and #17 and she confirmed the findings. She further stated that every Wednesday the managers have a stand-up discussion of all at risk situations, but do not specifically discuss risk residents. On at 5 PM, an interview with the Administrator confirmed the findings and stated that the facility does not complete risk assessments and every Wednesday the managers have a stand-up discussion about all risks. On . . . . . at 5:28 PM, an exit interview with the Administrator and DON, the Senior Regional Director of Operations was on the telephone listening in, and all agreed with the findings and had no further questions when asked. 4. On . . . . . a review of resident #3 record revealed a Resident Health Assessment form (1823) dated . . . . . . Her diagnoses included . . . , ... , lack of coordination, history of . . . , and moderate , . She required	A 025		

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A 025	Continued From page 8 assistance from staff for ambulation, bathing, , self-care, toileting, and transfer. A review of her Service Plan found it was updated with a on . The resulted in a transfer to the hospital for an evaluation. She was diagnosed with a nondisplaced of the right ischium. The intervention was to remind her to use the call device and continue hospice services. A review of the facility notes revealed: On at 3:45pm a note documented by the DON. Resident had a on . She was transferred to the hospital with a diagnosis of the right ischium. On at 4:23pm a note documented by the administrator. A reminder sign was posted in the resident's room to advise the resident to call for assistance prior to transferring. On at 9:54am a note documented by the DON. The resident had a with an emergency room evaluation on for hitting her . Upon return she was educated in the use of call pendants. On at 8:57am a note documented by the DON. Resident found on the floor in the bathroom. No visible injury or , . On at 4:51pm a note documented by the nurse on duty. Requested a nurse from hospice to assess the resident as she had and is very . Did not know who or where she was. On a note documented by the nurse on duty at 7:12am. The caregiver observed a resident kneeling on the floor. She was assisted to her wheelchair. She did not complain of , or injury. DON documented in focus note - Educated on use of call pendant.	A 025		

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A 025	Continued From page 9 A review of the residents Service Plan found it was updated with a on . The intervention was again to remind the resident to use the call device and continue hospice services. On at 4:45pm the Director of Nursing (DON) confirmed resident #3 had repeated . She provided the facility interventions for resident #3. They again included reminding the resident to use call device for assistance added and continue hospice services added . No other mitigating interventions were documented. Class III	A 025		