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 |
|---|---|---|---|
| | AL11963806 | A. BUILDING: _____ B. WING _____ | R 10/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ORMOND IN THE PINES | 101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174 |

| (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<br><br>A revisit to a change of ownership survey was conducted at Ormond in the Pines on . . . . . .<br><br>The facility had deficiencies related to the revisit at the time of the survey. | {A 000} | | |
| {A 161} SS=D | 429.275(2) FS; 59A-36.015(2) FAC Records - Staff<br><br>429.275<br>(2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule.<br><br>59A-36.015<br>(2) STAFF RECORDS.<br>(a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . . . . . In addition, records must contain the following, as applicable:<br>1. Documentation of compliance with all staff training and continuing education required by rule 59A-36.011, F.A.C.,<br>2. Copies of all licenses or certifications for all staff providing services that require licensing or certification,<br>3. Documentation of compliance with level 2 background screening for all staff subject to | {A 161} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11963806 | A. BUILDING: _____ B. WING _____ | R 10/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ORMOND IN THE PINES | 101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174 |

| (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 161} | Continued From page 1<br><br>screening requirements as specified in section 429.174, F.S., and rule 59A-36.010, F.A.C.,<br>4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to rule 59A-36.010, F.A.C.,<br>5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C.<br>(b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity ., to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in rule 59A-36.010, F.A.C.<br>(c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by rule 59A-36.010, F.A.C.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to maintain employee records with a copy of the job description for 2 of 4 employees reviewed (Employee D and B).<br><br>The findings include:<br><br>Record review of the employee file for Employee D, hired , found no evidence of a job description that included the employee's medication assistance aspect of her job.<br><br>Record review of the employee file for Employee B, hired , found no evidence of a job description. | {A 161} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11963806 | A. BUILDING: _____ B. WING _____ | R 10/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ORMOND IN THE PINES | 101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174 |

| (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 161} | Continued From page 2<br><br>During an interview with the Executive Director (ED) on [redacted] at 9:50 AM, he was asked to provide Employee D's job description that included medication assistance. He went through the employee file and could only locate the original job description for a caregiver that did not include the medication assistance responsibilities.<br><br>The ED was asked to provide the job description for Employee B, hired [redacted].<br><br>On [redacted] at 10:12 AM, the ED stated, he looked in Employee B's file and it did not have a job description.<br><br>Class III<br><br>. | {A 161} | | |
| {A 165} SS=D | 429.23( & ) FS Risk Mgmt & QA<br><br>429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.-<br>(1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences.<br>(2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means:<br>(a) An event over which facility personnel could | {A 165} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11963806 | A. BUILDING: _____ B. WING _____ | R 10/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ORMOND IN THE PINES | 101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174 |

| (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 165} | Continued From page 3<br>exercise control rather than as a result of the resident's condition and results in:<br>1. [illegible];<br>2. [illegible] or [illegible], [illegible] damage;<br>3. Permanent [illegible];<br>4. [illegible] or [illegible] of bones or joints;<br>5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;<br>6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or<br>7. An event that is reported to law enforcement or its personnel for investigation; or<br>(b) Resident elopement, if the elopement places the resident at risk of harm or injury.<br>(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.<br>(4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.<br>(6) [illegible], neglect, or [illegible] must be reported to the Department of Children and Families as required under chapter 415.<br>(7) The information reported to the agency | {A 165} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11963806 | A. BUILDING: _____ B. WING _____ | R 10/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ORMOND IN THE PINES | 101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174 |

| (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 165} | Continued From page 4<br><br>pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.<br>(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.<br>(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.<br>(10) The agency may adopt rules necessary to administer this section.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to submit a full adverse incident report through the agency's portal within 15-days of the event that included the facility's investigation and response for 1 of 1 resident | {A 165} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11963806 | A. BUILDING: _____ B. WING _____ | R 10/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ORMOND IN THE PINES | 101 CLYDE MORRIS BLVD ORMOND BEACH, FL 32174 |

| (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 165} | Continued From page 5<br>(Resident #11) that eloped from the facility on<br>.<br><br>The findings include:<br><br>During an interview with the Executive Director (ED) of the facility on at 9:12 AM, he was asked to provide proof of the submission of the 15-day adverse incident report related to Resident #11's elopement from the facility on . He attempted to find the report on his computer and could not locate it.<br><br>A review of the facility's 1-day adverse incident report involving Resident #1 revealed it was submitted to the Agency on . Further review of the report revealed the Agency administratively closed the report on , because requested information was not received from the provider. (Copy obtained)<br><br>During an interview with the ED on at approximately 10:10 AM, he was shown the report. After reviewing the report, he confirmed the findings. The ED explained the administrator at the time had informed him that she had resubmitted a complete report.<br><br>Class III | {A 165} | | |