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
	AL11969626	A. BUILDING: _____ B. WING _____	08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRIVE AT FERN PARK	7255 STRIVE PL FERN PARK, FL 32730

(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 Three complaint investigations #2023006565, #2023009377 and #2023011027 were conducted on and at Strive at Fern Park. A deficiency was found 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		

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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 interviews and record reviews the facility failed to provide appropriate supervision to prevent . . for 3 of 3 sampled residents #1, #2 and #,3). Findings: 1. In a review of resident#1's health assessment dated and an admission date of revealed a medical history of . . . . . , unsteady on , history of falling, ... , low . . . . . The resident needed assistance	A 025		

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A 025	Continued From page 2 with activities of daily living to include assistance with bathing and self-care, and assistance with medication. In review of resident #1's facility observation notes, revealed the following unwitnessed causing injury: Incident Report-Staff walked into the resident's room at 5am to check on resident and get the roommate up and found her on the floor sitting on butt. She stated she was walking to the bathroom. She had a small on her left . 10:22am Resident stated she in the bathroom in the middle of the night and hurt her lower . She stated her level was an 8 on the , scale. Residents' daughter saw her being wheeled to bed at 5am in a wheelchair and asked that she be assessed. Upon examination her , without cuts and . She was assisted to the bathroom because her , was so great, and she was . Sent to hospital and incurred a T12 because of the . 2. In a review of resident #2's health assessment dated and an admission date of revealed a medical history of , , , , OA, and Gait instability. The resident needed assistance with daily living to include assistance with ambulation, bathing, , self-care, toileting and transferring and assistance with medication. In review of resident #2's facility observation notes, revealed the following unwitnessed , with staff not sending the resident out to emergency room for hours which resulted in an injury: 10:49am Resident was from left , assess resident and saw that it was a deep	A 025		

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A 025	Continued From page 3 tear. Informed APRN and she called someone to come out to place . . . . . . 8:09 pm Several attempts were made by this writer and administrator to contact APRN to follow up on the person she contacted having not arrived at the community to treat resident's LLE skin opening. . . 8:53am Resident scraped the right side of her lower _ on the bracket of her wheelchair causing a . . . . . . APRN was notified and assessed to have a . . after scrapping the side of her _ getting out on the clasp that controls the _ rest. 3. In review of resident#3's health assessment dated . . . and an admission date of . . . . revealed a medical history of , , DM2, HLD, , . . . with HD MWF, , , . . . , , decreased responses, and forgetful Resident#3 required assistance with daily living to include supervision with ambulation, bathing, ... _, eating, self- care and assistance with toileting and transferring and assistance with medications. Resident was a . risk. In r review of resident#3's facility observation notes revealed the following unwitnessed : . . . . . 9:50am Resident found on the floor by the kitchen. She stated she out of her wheelchair and was not injured. She denied hitting her . . . . 12:50pm Resident found on the floor. She was attempting to walk to the table and . 911 called. 2:36pm Resident between her bed and reclining chair and pushed call button for assistance. . . . . 6:56pm Resident observed sitting on the floor in her room. Resident was beside her bed in	A 025		

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A 025	Continued From page 4 upright position. 6:02 pm Resident found on floor leaning against her recliner chair. Denies hitting her . 10:07pm Resident found on floor in room. No injuries noted. 11:54 am Resident found on floor no injuries noted. 3am Resident had a in the middle of the night from attempting to transfer. Resident suffered a skin to L . Resident verbalized she was not hurt. In an interview with staff C on at 12pm, she confirmed there were no interventions implemented for residents#1, #2 and #3. She stated she is not sure what the policy is, and she is not aware of the mitigation program. In an interview with staff, I on at 3pm, she confirmed she is not aware of intervention programs for risk residents. She stated she is not sure why resident#1 was not sent out to the hospital sooner. In review of the facility's policy, it confirms the facility shall establish and implement a mitigation program to diminish the risk of falling. In an interview on at 2pm, with the administrator she confirmed the above findings and stated resident#1 should have been sent to the emergency room sooner for the but the was under control and the APRN had called a third party to come to the facility to attend to the resident. She stated she should have made the call sooner. She stated she is aware that the risk residents should have an intervention plan to prevent these from occurring and will implement the policy in the future.	A 025		

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A 025	Continued From page 5 Class III	A 025		