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
	AL11968749	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	4725 BELLWETHER LN OXFORD, FL 34484

(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 An unannounced complaint investigation (complaint numbers 2023012221, 2023013536, 2023013538, and 2023015945) was conducted at The Willows on , through , . Deficiencies were identified at the time of the survey.	A 000		
A 030 SS=K	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close	A 030		

AHCA Form 3020-0001

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

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A 030	Continued From page 1	A 030		

proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and , ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible

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A 030	Continued From page 2 telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the	A 030		

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A 030	Continued From page 3 facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care ., and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally ., the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care	A 030		

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A 030	Continued From page 4 Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for	A 030		

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A 030	Continued From page 5 exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . . Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . , . . . or . . , ... under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents' rights were honored by not initiating , , ( ) and failing to implement the facility's policy and procedures when the resident was found unresponsive and absent of life, Resident #3. This had the potential to affect 52 residents at the facility who are a full code status [full code means medical support should be provided, including	A 030		

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A 030	Continued From page 6 . , if a resident has no heartbeat and is not breathing]. Findings include: Review of Resident #3's resident record revealed he was admitted to the facility on . . . . . and discharged on [the date the resident's belongings were removed from his apartment]. The record did not contain documentation of a . . . . . ( ) Order. An Emergency Data Summary form documented, "Code Status . ." Review of the progress note dated . . . . . read, "resident found in room at start of shift, care [sic] informed nurse on duty, this nurse was notified. It was reported resident was nonresponsive. The nurse arrived on scene, resident was laying [sic] down alongside table, only in underwear, call pendent across room on night table, chair nearby, tipped over basket from table on floor. [Executive Director's name] notified at 8:30am. 911 notified at 8:35am, arrived on scene at 8:45am. Police arrived on scene at 8:38am. PCP [Primary Care Physicians name] ARNP [Advanced Registered Nurse Practitioner] notified by phone at 8:43am. Daughter called and notified by this nurse at 8:48am, phone passed over to police. Investigation on going at this time. Medications in emar [Electronic Medication Administration Record] have been updated accordingly. Statements received from nurse and medtech [Medication Technician], information passed to ED [Executive Director]." Review of the facility's investigation completed on . . . . . read, "[Staff A's name] walked into resident's room, observed him lying flat on is [his]	A 030		

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A 030	Continued From page 7 . . . . . turned to left, away from me. I called out, got no response, observed resident was mottled, went to check for , . . . and noted he was already very ." Review of the facility's investigation completed on . . . . . at 2:17 PM regarding the . . . . of Resident #3 read, "Resident was last seen at approximately 7:30/8:00pm. Residents are independent and require no care. Resident did not have a . . While on the phone with . . [Emergency Medical Services], LPN . [Staff A's name] advised resident was . . . and partial blue and mottled. was not initiated. Upon arrival of and Wildwood Police at approximately 8:45am resident had passed." [Review of Resident #3's resident record did not contain documentation the resident was found , partial blue, and mottled]. During an interview on . . . . . at 10:52 AM, Staff A, Licensed Practical Nurse (LPN) stated, "It's kind of a blur but I do recall the incident. I was going in to do his . [Resident #3]. I entered the room, and he was laying there on the floor by his chair facing the wall. I could see when I opened the door that he was mottled meaning his skin was waxy, discolored kind of yellow and purple, I could tell he had been laying there awhile. I yelled his name. He didn't answer. I did not at any point do . on him. I did not start because I was in . , and I could tell that he had been there for a while. My immediate reaction, I ran out and called 911, called [Executive Director name] and everyone." [Review of www.crossroadshospice.com/hospice-resouces/end-of-lifesigns/mottled-skin-before- read, "Mottling is blotchy, red-purplish marbling of the skin. Mottling most frequently occurs first on the	A 030		

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A 030	Continued From page 8 . . . , then travels up the . ,. . Mottling of skin before is common and usually occurs during the final week of life, although in some cases it can occur earlier. Mottling is caused by the . . . no longer being able to pump . . . .. effectively. Because of this, , drops, causing extremities to feel cool to the touch. The skin then starts to become discolored."] During an interview on . . . . . at 11:43 AM the Nurse Practitioner (Resident #3's Primary Health Care Practitioner), stated, "He had been a patient of mine since of 2021. He was convinced to move into assisted living to manage his medications and his health issues. I was notified on the morning of . . . . . of him being found in his room unresponsive. I do not have a on file in his chart. I would assume that a nurse would do or , on him until . . arrived and took over because he is a full code. Only a Hospice Nurse or should be pronouncing a person . . . . ." During an interview on . . . . . at 12:33 PM, the Administrator stated she spoke with Staff A, and Staff A stated to her that she did not do because it was obvious he (Resident #3) was . . . . . . The Administrator stated, "My expectation would be if he was ice and discolored, I would not expect her to do . . . If he was discolored or and he didn't have a , . . . I would tell her . . . . needs to be done. I am not aware of the policy that was provided to you." During an interview on . . . . . at 12:44 PM, the Resident Wellness Director stated, "I was not working at the facility in . ,. . . or . , ... I am a Licensed Practical Nurse. Residents who	A 030		

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A 030	Continued From page 9 are found . . . . . , the staff would be expected to immediately start assistance if they do not have a . As a nurse I am not qualified to pronounce a person . None of my nurses are qualified to do that. A hospice nurse or can pronounce someone . Even if a resident was found mottled which means the skin is discolored when someone is in the process of dying, if they are . . . and if they had no , , you would still do ." During an interview on at 2:02 PM, the Administrator stated, "The bottom line is, if a resident does not have a then should have been administered." During an interview on at 3:03 PM the Administrator stated, "[Resident #3's name] was last seen leaving the dining room around 7:30 PM on with another male resident walking . . . to his room. I spoke to several staff and a resident by the name of [Resident #63 name] who confirmed this." During an interview on . . . . . at 8:52 AM, the Administrator stated, "An LPN cannot pronounce a person . . . . . We are not allowed to say if a person is . . . . It should be documented on the nurses note that the resident was ice and discolored, but I am not sure." The Administrator stated, "I am not sure it should have been documented [the description of Resident #3 being " . . . and partial blue and mottled"] in either the progress note, or on the incident report. I received the information from [Staff A's name]." During an interview on at 10:23 AM Resident #66 stated, "Yes, I recall [Resident #3's name]. [Resident #3's name] and I sat and had	A 030		

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A 030	Continued From page 10 dinner. [Resident #3's name] ate twice that night. We left the dining room and headed upstairs to our apartments at around a quarter to 7:00 PM or so. [Resident #3's name] went to his apartment and I went to mine. I did not see [Resident #3 name] anymore that day. I was told the next day that he ,[illegible]." Review of facility policy and procedure titled, "Resident Emergency- ", read, "There may be situations that cause a resident, staff member, or visitor to become . [illegible] may be caused by accidents, reactions, heat , and many other causes. What to do: 5. If the person is not breathing and has no heartbeat, clear the airway and perform ." Review of facility policy titled, "Healthcare Decision-making Policy," read, "1. The resident's healthcare decision-making choices are indicated on the Emergency Data Sheet as part of the pre-move-in process. 2. Copies of healthcare decision-making documents -events directives, [illegible] ( ), Medical Powers of Attorney, and Guardianship Orders-are obtained and made part of the resident record. 3. Summarize the resident's healthcare choices on a log sheet and/or Service plan and make it available for staff members to understand and follow. 4. Send copies of healthcare decision-making documents with the resident to the receiving facility when an emergency transfer takes place. 5. Update healthcare choices, records, and documents as needed to accurately reflect the resident's/resident representative's current choices. a. Update the emergency data sheet as needed." Review of facility policy titled, " Prohibition,"	A 030		

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A 030	Continued From page 11 read, "Neglect-The failure to provide goods and services necessary to avoid physical harm or mental anguish. Neglect is the failure to provide the necessary treatment, rehabilitation, care, attention, food, clothing, shelter, supervision, or medical services by a caregiver. Neglect is also creating situations in which esteem is not fostered. This could include instances where competent residents wishes are not honored restricting contact with family ignoring the residents need for verbal and emotional contact." Class I	A 030		