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 _____	R 10/12/2023

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

(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 revisit to a re-licensure #2022014023 survey was conducted on [redacted] at Greenwood Place Assisted Living facility. The deficiency remained uncorrected.	{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 [redacted] 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}		

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 _____	R 10/12/2023

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

(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 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: DEFICIENCY REMAINED UNCORRECTED Based on record reviews and interviews the facility failed to provide adequate supervision and provide care and services appropriate to meet the needs of residents by failing to ensure safety through proactive measures to minimize the potential for . . and injuries for 3 of 5 residents sampled (#1, #2, and #3). Findings: 1. On a review of resident #1 record revealed she was admitted on . Her record contained a Resident Health Assessment form	{A 025}		

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 _____	R 10/12/2023

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

(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 025}	Continued From page 2 (1823) dated . . . . . Her diagnoses included with behaviors, , ... , ... , ... left . , . , and hospice care. She required assistance with all activities of daily living. She required . precautions. A review of the facility notes revealed: On resident had a recent . (No documentation of recent .) On resident had a recent . (No documentation of recent .) On a facility note documented resident had a . on . . . . . Action: encourage resident to call for assistance. On . . . . . resident returned to the community from rehab on hospice. Encourage to attend activities and socialize, press pendant, and wait for assistance. (same as below) On . . . . resident returned to the community from rehab on hospice. Encourage to attend activities and socialize, press pendant, and wait for assistance. (same as below) On . . . . . a note that was time stamped 7:17am Late note - resident lying on her left side with . . . under bed. 911 transported her to the hospital. She returned at 2am with a diagnosis of . . . . . , . On . . . . Resident returned to the community on Hospice from rehab center. Encourage to attend activities and socialize, press pendant, and wait for assistance. On 9:35am resident noted to have in dining room. . . . contacted at 9:38am because she complained of right , , . A review of her facility Service Plan revealed it was last updated on . . . . . She was at risk for , . Her last assessment was dated . . . . . and documented at high risk for .	{A 025}		

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 _____	R 10/12/2023

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

(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 025}	Continued From page 3 2. A review of resident #3 record revealed she was admitted on . Her record contained an 1823 dated . Her diagnoses included left , , and . She required the use of a walker and a wheelchair. She also required assistance with transfer and ambulation. A review of an incident report revealed on at 12:55pm resident #3 was found in a kneeling position in her apartment. She was transferred to the hospital with a diagnosis of right . A review of the facility notes revealed: On resident returned from rehab at 11:30pm. There were no notes available prior to . Her Service Plan was dated . Review of Service Plan found it was blank. A evaluation dated indicated she was at high risk for falling. 3. A review of resident #2 record revealed he was admitted on . His record contained an 1823 dated which had documented under special precautions. His diagnoses included , , 's, and , . Review of the facility notes revealed: On Resident found on the floor 4:30am from the . Resident transported to the hospital with a diagnosis of a . On Resident found on the floor down by bed. On Resident in the dining room.	{A 025}		

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 _____	R 10/12/2023

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

(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 025}	Continued From page 4 , sweating, and leaning to the left side. Transferred to the hospital. On resident was on the floor in his apartment in a prone position. Admitted to hospice. On resident found on the floor in his apartment on . He was transferred to the hospital. Upon return he was educated on calling for assistance. On resident on the floor in apartment. Refused to go to the hospital. On time stamped 10:59am resident found on the floor at the of the bed. He complained of and was transferred to the hospital. On returned at 1am from the hospital with no abnormal findings. On resident slid off the bench at the end of the bed. Review of resident #2 Service Plan last updated on revealed no interventions were documented. On eval review revealed he was at moderate risk for The first question -"Has resident before?" was marked "NO" A review of the facility management program dated revealed the facility would focus on risk evaluation, medication management, environmental modifications, and exercise to maximize effectiveness of the program, and associate training. The community would evaluate each resident for risk of , design an individualized service plan, and implement procedures to minimize and/or injury. On at 3:50pm all the above findings	{A 025}		

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 _____	R 10/12/2023

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

(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 025}	Continued From page 5 were confirmed by the administrator. She said the staff were currently being trained on the new Management Program and updating resident service plans. Class II	{A 025}		