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
	AL11968448	A. BUILDING: _____ B. WING _____	11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENADES BY -WEST ORANGE	720 ROPER ROAD WINTER GARDEN, FL 34787

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A 000	Initial Comments A complaint investigation (#2023012423) was conducted at Serenades by - West Orange on and . The facility had a deficiency at the time of the survey.	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 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		

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 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 record reviews and interviews, the facility failed to provide adequate supervision to prevent resident on resident for 3 of 6 sampled residents (#2, #10, #11) that resulted in injuries and failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for and injuries for 2 of 6 sampled residents (#1, #8). Findings: A review of resident #2's record revealed a facility admission date of . The resident's medical	A 025		

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A 025	Continued From page 2 history included . . . . . . A review of resident #10's record revealed an admission date of . The resident's medical history included . . . . Both a and a facility evaluation documented the resident did not exhibit present or past behavioral issues. A review of resident #11's record revealed a facility admission date of . . . . The resident's medical history included 's . A review of facility documentation revealed the following: On . . . . . 10:27 pm resident #10 continued exit seeking and having aggressive behaviors towards both staff and residents. Emergency medical services were notified, and the resident was taken to a hospital. On . . . . . 11 pm resident #10 returned from the hospital. On at 6:13 pm resident #11 was standing in the hallway near the dining room . . . . . , from the left side of his . Resident #10 was awake, alert, and angry the whole time. The nurse took resident #10 down the hallway away from the other residents and called 911. Caregiver K reported that she was providing care to a resident in another room when she heard yelling out in the hallway. When caregiver K went out to the hallway, resident #11 was laying on the ground, up and , from his and resident #10 was standing nearby with a stick in his . Caregiver K walked up to resident #10 and took the stick away from him. 911 was called and rendered aid to resident #11 and transported	A 025		

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A 025	Continued From page 3 him to a hospital. Resident #10 was also sent to the same hospital for . A hospital discharge summary documented resident #10 was seen for battery with a diagnosis of 's. On 10:49 am resident #10 was from the hospital and was in the common area with his family member until a private sitter arrived. On 3:36 pm resident #10's family was informed that the resident was upset and unable to be redirected by his sitter. The resident picked up a side table and threw it at his bedroom door then proceeded to go unit to unit. He was upset until he finally came to "Brio" unit where he was able to be redirected with coffee. Hospice was notified to review his medications and to see him. On 9 pm resident #10 became agitated that his sitter was in his room. He took a device similar to a cane handle and tried to hit the sitter without success. The object was removed from his room. On 10:40 pm the director of nursing at the time said resident #10 no longer needed a private sitter. On 9:47 pm resident #10 was walking throughout the unit. He showed signs of , and . Frequent redirection was provided. On 5:45 pm resident #10 had been agitated for the past two evenings, going from unit to unit, and talking about making a group and having residents sign a petition. A nurse tried	A 025		

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A 025	Continued From page 4 reality orientation. On . . . . . 3:35 pm resident #10 was very agitated and exit seeking. He was observed pulling the secured doors from the courtyard and entered the main lobby area. With persistent persuading the resident was able to be redirected and escorted into the unit. The resident was very agitated stating that he was being tortured. The nurse was able to redirect his aggression and attention by engaging him in conversation and reassuring him that no one was being tortured. Hospice was notified. The resident's 0.5 milligrams was increased from twice daily to three times a day. On . . . . . 5:54 pm resident #10 went out a side door. A staff member went outside with him, and they walked around. The administrator informed the resident's family they would have to provide a private sitter. The sitter arrived at approximately 4 pm. On at approximately 11:55 pm nurse A was called to go to "Brio" unit to assist resident #10, who was being aggressive. When the nurse arrived resident #10 was at the other end of the unit by the doors to "Calore" unit with his private sitter at his side. Staff reported that resident #10 knocked a large container of water onto the floor towards a resident assistant then began to laugh. Resident #10 then walked down the hallway while caregiver B and the private sitter cleaned up the water. At this time, resident #10 walked into resident #2's room. Staff then heard yelling coming from the room and when they entered, resident #10 was standing over resident #2, who was laying in his bed and yelling "help me". Resident #10 had some type of wooden , , , . that was taken off resident #2's dresser and	A 025		

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A 025	Continued From page 5 resident #2 was [redacted] from the top of his [redacted]. The staff immediately removed resident #10 from the room and contacted nurse A. When the nurse arrived, 911 was called for both residents. Law enforcement responded and documented the incident. An [redacted] hospital discharge summary documented resident #2 was seen for a battery and was diagnosed with [redacted] injury, assault, [redacted]. A [redacted] of the resident's [redacted] revealed no acute abnormalities. On [redacted] 7:10 am resident #2 returned from the hospital. On [redacted] 5:28 pm the administrator confirmed with resident #10's family that a 24-hour sitter would be in place and ongoing. The administrator also asked the family to hire a new sitter company due to the previous sitter leaving the resident to clean up water. On [redacted] at 4:06 pm, private sitter J, who was the sitter during the incident between residents #2 and #10 on [redacted], said resident #10 woke at approximately 11 pm on [redacted] and wanted to leave the facility. The sitter followed the resident around the unit. The resident became upset with the sitter when he tried to stop the resident. The resident was in the dining room when he became agitated and hit a pitcher of water, which [redacted] on the ground spilling water. The sitter said he saw the resident go to his own room. The sitter went to get something to clean up the water when he heard a noise. A facility caregiver told sitter J the resident went into another resident's room. The sitter did not see the resident go into that other room. The sitter went to the other resident's room and saw [redacted] on resident #2's [redacted]. The sitter	A 025		

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A 025	Continued From page 6 said regarding resident #10, "he liked to fight". The sitter said he received training on working with residents with through online learning. He said he learned of the resident's past aggression with other residents from his agency co-workers. He said the facility did not provide him with training on the residents' behaviors. On at 4:46 pm, caregiver B said she was doing room checks when she entered resident #2's room and saw on resident #2's . Resident #10 was also in the room holding something, she could not recall what it was. She exited the room and called out for nurse A, who was passing meds on the unit. Caregiver B said resident #10 was very aggressive and went after other residents. She said he had to be watched. She said she received training on the facility's policy upon hire. She said she did not receive additional training after the incident involving residents #2 and #10. The facility's undated resident to resident policy read, in part, the community will provide ancillary training regarding related policies and procedures, will provide ancillary education for those additional individuals involved with the resident, will develop a plan of care to meet the resident's needs, will update the resident's service plan, and will orient each caregiver and team to plans and approaches. On at 8:55 am, the administrator was asked to review the facility's resident to resident policy and to provide documentation that the policy was followed for resident #10. On at 9:20 am, nurse C said her experience and observations with resident #10 was that he oftentimes became frustrated and	A 025		

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A 025	Continued From page 7 raised his arms in agitation towards staff when they tried to do anything with him. She said oftentimes he had to be moved to another table and away from other residents because of his disruptive behaviors, loudly calling out and making random noises. She said she'd never witnessed him be aggressive or towards other residents. She said she never received training specific to him, such as behavior management. On at 9:50 am, the administrator provided the following: a document that indicated an in-service was given in on involving residents in activities, resident to resident (10:10 am the administrator said there was no documentation of what specifically was discussed) and part 1 training (given by a hospice provider), a "shift checklist/rounds" in-service on , a hospice note that indicated resident #10's psych meds were adjusted, and an notice of immediate termination of residency for resident #10. On at 10:10 am, the administrator said resident #10's care plan would have been available for care staff to access on a computer. Review of the care plan she provided did not address the resident's aggressive behaviors and management of such behaviors. Resident #1's record review revealed date of admission on . The 1823 Health Assessment dated listed medical history of , , , , recurrent , and a history of Mental illness. Her physical limitations are wheelchair bound and only alert to self. She needs assistance with activities of daily living	A 025		

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A 025	Continued From page 8 (ADLs) with bathing, , eating, and grooming. She needs total help with ambulation, toileting and transferring. She needs assistance with self-administration of medications with order dated to crush medications in applesauce. She was approved Hospice care on but family declined the services. Resident #1 was documented as a precaution and below the facility notes documented a total of ten (10) total from admission date to the present day as follows: 1 on at 3:48 PM by nurse A documented that resident #1 was sitting in her wheelchair after breakfast in the Adagio neighborhood living room. Resident #1 continued to stand up from the wheelchair even after care staff kept asking resident #1 to sit down several times. Resident #1 was given a , as needed for the restlessness. Resident #1 stood up again from her wheelchair and walked over to the large ottoman and, laid down and went to sleep. Resident #1 rolled over and rolled onto the floor and bumped her on the wall. Observed resident #1 having a quarter sized hematoma to the left side of her forehead. Resident #1 sat up and held her . Applied ice to hematoma. 911 was called, notified son about . Resident #1 was transported to hospital. 2 on at 9:52 PM by nurse A documented she was in the Adagio neighborhood living room at the med cart and suddenly heard a noise coming from down the hallway. Nurse A found resident #1 laying on her bedroom floor next to the bed on her right side, awake and alert. Nurse A slid a pillow under resident #1's and resident #1 stated that she had hit her . 911 was called and resident #1 was transported to the	A 025		

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A 025	Continued From page 9 hospital. 3 on at 7:26 AM by nurse H documented that on at 4:10 PM, resident #1 was in Adagio neighborhood common area and resident #1 was found sitting on floor. Resident #1 was not being , to explain how she but resident #1 did say that she did not hit her . The physician and son notified. The facility will continue to monitor. 4 on , an incident at 5:56 PM by nurse A documented that on at 4:48 PM resident #1 was found lying on the floor next to her bed on her right side. Resident #1 was awake, alert and nude with no clothes on. Resident #1 had taken all her clothes off. Resident #1 complained of to the right - , area. 911 was called and resident #1 was transported to the hospital via stretcher. The physician and son notified, no answer with son. Left message to son. 5 on , an incident at 12:03 PM by nurse G documented resident #1 was found lying on her left side on the floor next to the sofa in Adagio neighborhood common area. Resident #1 lost her balance and hitting her . 911 was called and resident #1 was transported to hospital. The physician and son were notified. 6 on , an incident at 1:14 PM by nurse H documented that on at 12:30 PM resident #1 had been nodding on and off in her wheelchair. Resident #1 was found lying in bathroom doorway lying on left side. Resident #1 was , and was coming from her and the started to swell with discolor. 911 was called and resident #1 was transported to the hospital. The physician and son notified.	A 025		

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A 025	Continued From page 10	A 025		

7 on at 2:56 PM by nurse I documented that she observed resident #1 laying with blanket over her and she was on her right side on the floor by the med cart. It was unclear if this was a or if the resident #1 laid down. Resident #1 did not have any complaints of , and no physical signs of injury observed.

On at 9:27 AM, the Administrator documented that she called the family and left a voicemail message about getting a mat and lowering the bed for resident #1 to prevent . Resident #1 was approved for Hospice services, but the family declined the hospice services at this time but would like the home Health agency to continue coming with more , , , , and , , to help with concerns towards utilizing walker and not getting up without assistance. A private sitter was put in place every day from 1pm-5pm to help minimize and prevent .

8 on at 9:34 AM by nurse H documented that she observed resident #1 sitting on floor in front of couch against wall, and her wheelchair was next to couch. Resident #1 was trying to stand up but became unsteady and to the floor. Nurse H stated that she couldn't get to resident #1 in time. Resident #1 denied any , after being assessed with no injury. Resident #1 was wearing non-skid socks. Notified the physician and son. Will continue to monitor.

9 on at 7:37 AM by nurse A documented that on at 6:51 AM, an unexplained , and cuts type injury with discoloration was observed to the right , right cheek, and right . Resident #1 was asked what happened but resident #1 was not able to

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A 025	Continued From page 11 answer due to mental status and she could not recall. There was no observed. Resident #1 was able to move her right without any discomfort. Notified son and physician. Will continue to monitor. 10 on at 9:11 AM by LPN documented on at 3:05 AM with injury nurse on duty went to Adagio living room resident had rolled off the couch onto the floor while she was sleeping. Resident was able to move all extremities without complaint of discomfort or grimacing. The bridge of looked red appears resident scraped it. Son, physician, and Hospice notified. Will continue to monitor. The negotiated risk assessment for was completed and signed on , after five (5) after admission into the facility. The facility failed to assess resident #1 for precaution appropriately and timely after the 1st occurrence. On at 4:05 PM, an exit interview with the Administrator confirmed the findings and further stated that resident #1 had just again today and she was sent out to the hospital to be checked. (Photographic Evidence Obtained) 2. Resident #8's record review revealed admission date . The last 1823 Health Assessment dated listed medical history of Essential primary , , with behavioral disturbances, Bed confinement status, , of	A 025		

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A 025	Continued From page 12 the , , , , , , major , , Kyphosis and Lordosis and leakage of . She was currently on Hospice care with 3 liters via of continuous since . Resident #1 needs assistance with self-administration of medication. Resident #8 , from natural causes with Hospice at the facility on . There was documented evidence that resident #8 had two (2) before the of a pubic on . A facility note documented, 1 with no injury on at 10:33 PM by a nurse no longer working at the facility documented resident #8 had a witnessed while sitting in the wheelchair in the common area of the Brio neighborhood. Resident #8 was unable to make a clear statement about how she but stated to nurse "this is not plugged into the wall, and it has to be plugged in. I can't figure out how to plug this in and it was always plugged in at home ". Resident #8 was holding a portable and showed it to the nurse. Resident #8 made a loud noise and staff witnessed resident #8 sliding out of her wheelchair and onto the floor. Resident #8 stated that she did not hit her . Vitals checked. Resident #8 had no complaint of , and discomfort. Assisted resident #8 into her wheelchair. There was no discoloration to the skin. The spouse and Hospice were notified. Will continue to monitor. 2 on at 9:28 PM by nurse A documented that on at 4:17 PM, resident #8 slid out of her wheelchair this afternoon trying to save her large cup of ice	A 025		

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A 025	Continued From page 13 water. Resident #8 sustained a small on her right and an to her left . First aid was administered. Resident #8 denied any discomfort and , . Resident #8 was currently resting. A message was left for her husband about the . Hospice was notified and stated they would send a hospice nurse out tonight to assess resident #8. Will continue to monitor. 3 on , an adverse at 3:04 PM by nurse G documented that in the Brio neighborhood resident #8 was screaming upon entering her bathroom. Resident #8 was unable to apply to her lower abdomen extremity and a bone , with discoloration and was to area. 911 called and resident #8 was transported resident to the hospital. The spouse and hospice were notified. On (next day) at 12:09 PM by nurse A documented resident #8 returned to the community last night on at 11:38 PM via medical transport. Resident #8 had new orders 500 mg, to take 1 capsule by 4 times a day for 10 days for a , (). The spouse did not want resident #8 to be transferred from ALF and was unclear the cause, possibly the , that resident #8 started to complain about. The hospital record findings were a and a pubic . The spouse agreed to the for and , for the pubic but refused any other further imaging test or interventions for resident #8. He expressed that resident #8 , can be treated by the facility. The hospice nurse also came today and found a to resident #8's left and bottom of right . The hospice nurse obtained orders to evaluate and treat until it is healed. Resident #8 has a protective , to	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968448	A. BUILDING: _____ B. WING _____	11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENADES BY -WEST ORANGE	720 ROPER ROAD WINTER GARDEN, FL 34787

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A 025	Continued From page 14 right [redacted] for protection. Resident #8 was up in her wheelchair this morning and had breakfast in the dining room. Resident #8 has denied [redacted] all morning but observed that the left [redacted] is but no [redacted] noted. Will continue to monitor. The negotiated risk assessment for [redacted] was completed and signed on [redacted]. (Photographic Evidence Obtained) A hospital record dated [redacted] documented closed, left [redacted], pubic [redacted]. There were no [redacted] precaution interventions put in place for resident #8 except for the hospice nurse who came to assess and cared for her. There was no [redacted] and [redacted] initiated. On [redacted] at 4:10 PM, an interview with the Administrator confirmed the findings. Class II	A 025		