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
	AL11969324	A. BUILDING: _____ B. WING _____	12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE ASSISTED LIVING FACILITY	533 E CITRUS ST ALTAMONTE SPRINGS, FL 32701

(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 complaint investigation #2023014197 was conducted on [redacted] at Divine Assisted Living, Altamonte Springs. 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 [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		

AHCA Form 3020-0001

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

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
	AL11969324	A. BUILDING: _____ B. WING _____	12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE ASSISTED LIVING FACILITY	533 E CITRUS ST ALTAMONTE SPRINGS, FL 32701

(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: Based on record review and interviews the facility failed to provide care and services appropriate to meet the needs of a resident by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for [redacted] and injuries for 1 out 2 sampled residents (#1). Findings: In a record review of resident #1's health assessment dated [redacted] it revealed a medical history of [redacted], and needs assistance with daily living to include suspension with mobility, bathing, [redacted], eating, self-care,	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
	AL11969324	A. BUILDING: _____ B. WING _____	12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE ASSISTED LIVING FACILITY	533 E CITRUS ST ALTAMONTE SPRINGS, FL 32701

(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 toileting, transferring and supervision with ambulation and transferring. In further review, the facility progress notes document unwitnessed on , resident found on floor, , , and . The resident is no longer at the facility. There was no intervention or prevention program available for the resident. In a review of the facility's policy, it states look for , or injury let administrator, physician and family know. Depending on response will call 911 if nonresponsive call 911. This policy was not followed for resident#1's on . In review of the facility's incident reporting policy, it states the provider shall document any incident, major or uncommon, and action taken responsive to that. The family/representative, health care provider, and 911 will be notified as applicable. An injury to a resident which requires treatment and assessment by a health care provider, the record must include a description of the circumstance under which the injury occurred. In review of the facility's incident report dated for resident#1, it states staff found resident on the floor side. Resident was able to turn to other side. Staff assisted him up. The residents denies , , no injury or observed. Treated by physician- no, hospital admission- no. Hematoma noted on right , . In an interview on with staff A, she stated she just started the job but is not aware of residents having a risk intervention or prevention program. She stated she calls 911 if a resident is . She stated she was not	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
	AL11969324	A. BUILDING: _____ B. WING _____	12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE ASSISTED LIVING FACILITY	533 E CITRUS ST ALTAMONTE SPRINGS, FL 32701

(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 here when resident#1 was residing here, however she reports any injuries to the administrator and is not aware of any increased supervision for residents who are risk. The resident is no longer at the facility. There was no intervention or prevention program available for the residents. In an interview on at 1pm with the administrator, she confirmed the above statements. She stated she was not at the facility when the incident happened, and the staff followed protocol. Photographic Evidence Obtained Class III	A 025		