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
	AL11967960	A. BUILDING: _____ B. WING _____	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAMA LLAMA LLC	1074 C/D HYACINTH PLACE WELLINGTON, FL 33414

(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 Relicensure and Complaint (#2023014576, #2023014820) and Generator Monitoring survey was conducted on through [redacted] at Mama Llama LLC. The facility had deficiencies related to the Relicensure and Complaint 2023014820 survey 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 [redacted] 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 [redacted] or [redacted]. 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 [redacted] 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,	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 including the following: (a) Monitoring of the quantity and quality of 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 records review and interviews, it was determined that lack supervision by a facility employee resulted in a preventable with injuries of 1 of 2 sampled Residents (Resident #12). The findings included: Resident #12 was admitted to the facility on . The health assessment (AHCA form 1823) dated revealed the following diagnoses: Advanced	A 025		

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A 025	Continued From page 2	A 025		

gain; , due to physiological condition, history of behavior disturbance, with improvement. The AHCA form 1823 revealed that Resident #12 had gait Ataxia (a condition that causes a lack of voluntary coordination); she was wheelchair bound, and required two persons' assistance for limited walking, but one person assistance for transfer. Resident #12 was alert and oriented to self only. Resident #12 required assistance for all activities of daily living.

The facility's incident report dated revealed that Resident #12 sustained a with major injuries. The record documented that Resident was taken to the bathroom for toileting by Employee C, a certified nursing assistant (CNA),. While Resident #12 sat on the toilet seat, Employee C left Resident #12 unsupervised and went to the Resident's closet to take new clothes for the Resident. Resident #12 then got up from her toilet seat and attempted to walk into her room with her pants still down. Lacking gait stability, and with her pants down, Resident #12 down on her and broke her jaw and a . Employee assigned to supervise Resident #12 was in the Resident's closet which is located in the bathroom during that time. The incident report documented that the Employee heard the noise resulting from the while she was in the closet.

Resident #12 in her room approximately ten away from the toilet bowl. A door divides the bathroom from the bedroom. The bedroom closet is located two away from the toilet bowl and is inside the bathroom area, on the right side, as one enters the bathroom. Since Employee C was in the closet and did no maintain direct

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A 025	Continued From page 3 contact on Resident # 12, she could not prevent the Resident from falling. The Administrator reported on at 1:54 PM, that after the , Resident #12 was sent to the hospital via ambulance. After her treatment from the hospital, she was discharged to a rehabilitation center. The Administrator added that she knew Resident #12 went to the Rehabilitation Center because the facility had called requesting Resident #12's medical records and health assessment. The Administrator also reported that the employee who was responsible for Resident #12'care the day the Resident was terminated for not following protocol or the facility's policy. Employee B, a Certified Nursing Assistant (CNA), reported on at 2:01 PM, that she too learned that residents should not be left unattended during care. Employee B said, if for some reason they need to leave, they must ask another staff to watch over the resident before they do. Employee A, a Certified Nursing Assistant (CNA), said on at 2:30 PM that all employees were instructed to not leave their residents, especially those who have and physical , unattended during care. Review of the record dated documented that Resident #12's was caused by "complications of blunt " as well as " ". Resident #12 two months after her from the facility.. The findings were discussed with the New Administrative staff on at 9:31 AM. She	A 025		

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A 025	Continued From page 4 said that she understood and provided no additional information. Class III	A 025		