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
	AL11969028	A. BUILDING: _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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
CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	CZ821		

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CZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	CZ821		

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CZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	CZ821		

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CZ821	Continued From page 3 to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to submit electronically the one-day adverse incident report and a 15-day (full report) to the agency (Agency for Healthcare Administration) for 2 of 6 sampled residents (#1, #2) as required when they went to the hospital for a higher acuity for multiple . Findings: 1. Resident #1's record review revealed admission date . The last 1823 Health Assessment dated listed medical history of , with , moderate , current tobacco , statis, , total surgery and completed repair of right . She needs assistance with all activities of daily living (ADLs) in ambulation, bathing, , grooming, toileting and transferring and independent with eating. Resident #1 ambulates by wheelchair and needs assistance with self-administration of medications.	CZ821		

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CZ821	Continued From page 4 Resident #1's history of was a total of seventeen (17) times with no interventions put in place in the timeframes of (within six months). The most recent occurred on at 7:50 AM, the Resident Service Director ( ) documented Resident #1 was trying to transfer to the couch from the wheelchair and missed the couch, slid on the floor and there were no apparent injuries. Resident #1 was assisted to her wheelchair and her sister, and the Nurse Practitioner was notified. Later, the night of at 10:41 PM, Nurse A documented Resident #1 was sitting in her recliner chair while getting her bed ready and changing her. Resident #1 became very resistant and started pulling away. Resident #1's right got caught under her bed frame resulting in a large with a moderate amount of and pressure was applied. There was no documented evidence that 911 was called and that the facility notified the family and physician of the incident. On at 3 PM, an interview with the Resident Service Director ( ) confirmed that Resident #1 was sent out to the emergency room to be evaluated and treated. On at 7 AM, Nurse E documented Resident #1 returned from the hospital from the lower sliced from her bed frame. Resident #1 was given a shot and new orders for and 2% . Follow up with the physician in 10 days. Nurse E placed wrap over the sharp area of the bed.	CZ821		

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CZ821	Continued From page 5 2. Resident #2's record review revealed admission date . . . . . The 1823 Health Assessment dated listed medical history of multiple . . . . . of the . . , a subsequent encounter for with routine healing, speech and language . . . . . following unspecified . . , an encounter for other orthopedic aftercare, , , , presence of , and severe protein calorie . . . . . Resident #2 ambulates by wheelchair with a . . risk precaution. Resident #2 needs assistance with activities of daily living (ADLs) in ambulation, bathing, . . . , grooming, toileting and transferring and independent with eating. Resident #2 needs assistance with self-administration of medications. Resident #2's history of was a total of seven (7) times with no . . interventions put in place in the timeframes of - . . (within three months). The most recent . . occurred on . . . . . at 7:41 AM, Nurse F documented Resident #2 was found on the floor trying to walk to the bathroom without her wheelchair and did not request assistance. Resident #2 denied hitting her . . . , but she said her left . . hurts. Nurse F ordered an . . . . Resident #2 was refusing to go to the emergency room. Vitals normal and her family and physician were notified. On . . . . . at 7:23 PM, Nurse A documented received the left , and , /, , results. The left has an acute . . radial with mild displacement. The , and	CZ821		

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CZ821	Continued From page 6 , , were negative. The Nurse Practioner requested Resident #2 to be sent to the hospital. There was no documented evidence that the family was notified of the left and sent to the hospital. On at 5:10 PM, an interview with the Administrator confirmed the findings and further stated that he did not electronically submit an adverse report to the agency required. Unclassified	CZ821		
A 000	Initial Comments There were two Complaint Investigations #2024002580 and #2024004680 & a generator monitoring was conducted at Zon Beachside LLC. Assisted Living Facility & Memory Care on . The facility had deficiencies at the time of the survey visit.	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	A 025		

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A 025	Continued From page 7 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 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	A 025		

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A 025	Continued From page 8 additional services. This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to ensure that appropriate supervision to meet the care and services by implementing a more defined systematic measures to maintain safety interventions for multiple and documenting the well-being such as significant changes and legal representative being notified for 2 of 6 sampled residents (#1, #2) as required. Findings: 1. Resident #1's record review revealed admission date . The last 1823 Health Assessment dated listed medical history of , , , , , , with , , moderate , , , current tobacco , , statis, , total , , surgery and completed repair of right . She needs assistance with all activities of daily living (ADLs) in ambulation, bathing, , grooming, toileting and transferring and independent with eating. Resident #1 ambulates by wheelchair and needs assistance with self-administration of medications. In further review, the facility notes documented between six months - , Resident #1's history of was a total of seventeen (17) times with no interventions put in place as documented below:	A 025		

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A 025	Continued From page 9 On . . . . . at 6:51 AM, Nurse E documented Resident #1 was found crawling on the floor. Resident #1 said she had lost her balance in her closet looking for her pants to put on. Resident #1 denied hitting her . . . and not complaining of , . No injuries observed. The family and Nurse Practitioner were notified. On . . . . . at 3:54 AM, Nurse E documented Resident #1 was calling for help. Resident #1 was near her front door crawling and stated that she slid off her bed. No injuries observed and assisted her . . . into bed without any problems. Will continue to monitor. There was no documented evidence that the family and physician were notified after this . . On . . . at 6:25 AM, Nurse E documented that approximately at 11 PM, Resident #1 was found on the floor on her . . . near her bathroom. Resident #1 stated that she was walking out of her bathroom and tripped landing on her . Resident #1 said her does hurt a bit and refused 911 to be called. Resident #1 denied , and , . Vitals normal range and assisted Resident #1 . . . into her recliner chair. Resident #1 had no and no visible marks. Will continue to monitor. There was no documented evidence that the family and physician were notified after this . On at 10:39 AM, the Assistant Director of Resident Services (ADRS) documented that the housekeeper had informed her that Resident #1 had . . . . Resident #1 was observed on the floor with her against her recliner chair. When asked Resident #1 what happened, she answered that she slid off the recliner chair.	A 025		

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A 025	Continued From page 10 Resident #1 had no complaint of , and assisted Resident #1 getting dressed. The sister and physician were notified. On at 6:28 PM, Nurse A documented Resident #1 was found on the floor in her apartment in front of her recliner chair. Resident #1 said that she was trying to get out of her recliner to get to her walker. Resident #1 denied , and no injuries observed. Resident #1 was able to move all her extremities. Nurse A reminded Resident #1 to push her pendant when she needs help. There was no documented evidence that the family and physician were notified after this . On at 9:46 PM, Nurse A documented Resident #1 yelled help, help. Resident #1 was lying on her floor in the kitchen. Resident #1 stated that she was tidying up things and . Nurse A assisted Resident #1 from the floor. A new to left inner was observed, applied first aid and reminded the Resident #1 to push pendant for assistance. There was no documented evidence that the family and physician were notified after this . On at 8:40 PM, Nurse C documented that she had walked past the Resident #1's room and heard her yelling for help. Resident #1 was found lying on on her floor in the bathroom. Resident #1 could not recall how she . Resident #1 said she did not use the call pendant. Resident #1 was assisted off the floor into standing position into her wheelchair. A small to the left was cleaned and dressed. No other complaints of , and denied hitting her . The sister and physician were	A 025		

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A 025	Continued From page 11 notified. On ..... at 6:37 PM, Nurse B documented Resident #1 was observed in seated position on the floor in front of her recliner chair. Resident #1 stated that she was not in , . Nurse B observed that Resident #1 had reopened her two healed to left arm, dressed and covered. Resident #1 was assisted in a standing position and sat into her recliner chair. The family and physician were notified. On ..... at 7:16 AM, Nurse D documented Resident #1 was found sitting on the floor in front her bed. Resident #1 stated that she was trying to get up out of her bed to go the bathroom and slipped when getting out of her bed. Resident #1 denied , and discomfort. Resident #1 was able move all extremities and there were no open areas and no redness. Resident #1 denied hitting her ... and assisted Resident #1 off the floor and into the bathroom then to bed. There was no documented evidence that the family and physician were notified after this .. On at 7:25 AM, Nurse E documented Resident #1 was heard yelling "help me" at 6:15 AM. Nurse E was just in resident's ... minutes ago and Resident #1 was asleep. Resident #1 stated she had ... and was out of breath. A re-tear on the left arm was observed. First aid and ... aid applied. Resident #1 stated that she wanted to go to bed. Vitals normal and as needed breathing inhaler was given. Notified the sister and physician. On at 10:32 PM, Nurse A documented Resident #1 had just had a shower and assisted her to her recliner chair. About 3 to 5 minutes	A 025		

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A 025	Continued From page 12 later, heard Resident #1 yelling for help and found her on the floor sitting on her bottom in front of her recliner chair. Resident #1 said she slipped off the recliner chair. Resident #1 denied , and no injuries observed. There was no documented evidence that the family and physician were notified after this . On at 7:20 AM, Nurse E documented Resident #1 was yelling for help and found sitting on the floor at 5 AM in her room. Resident #1 denied hitting her . . . . No injuries observed. Resident #1 could not tell me how she or what happened. Nurse E assisted Resident #1 into bed and reminded her to push the pendant and wait for help before getting up on her own. The family and physician were notified. On at 4:18 AM, Nurse D documented Resident #1 was heard calling for help. Found Resident #1 laying on her with rolling walker out in front of her in her room. Resident #1 stated she was walking and lost her balance and . Resident #1 was able to move all extremities freely and vitals checked. Resident #1 also stated that she bumped her . . . . when laying down on the floor. There were no raised areas on her . and assisted Resident #1 . . . . up off the floor and . into her bed. There was no documented evidence that the family and physician were notified after this . . On . . . . . at 8:49 PM, Nurse C documented Resident #1 was observed in doorway of her apartment lying on her . . . . Resident #1 could not recall how she . Nurse C observed the walker was not locking properly and advised her to use her wheelchair for the time being. Notified	A 025		

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A 025	Continued From page 13 the sister about the walker being unsafe to use. Resident #1 was assisted up in standing position and observed a to left was not , but weeping . Nurse C dressed the and notified the family and physician. On at 8:45 PM, Nurse B documented Resident #1 was found on the floor, lying on her in the doorway of the bathroom. Nurse B asked Resident #1 if she hit her or if her hurt. Resident #1 answered, "my does not hurt". Resident #1 was assisted to standing position into her wheelchair. The physician and family were notified. On at 10:41 PM, Nurse A documented Resident #1 had an episode of . Resident #1 was cleaned and ready for bed when Resident #1 was found on the kitchen floor lying in supine position. Resident #1 said I hit my a little. Resident #1 complained of , when attempting to get up off the floor. Notified the sister and sister stated do not send Resident #1 to the hospital. Furthermore, the sister stated that she had watched the on the camera and confirmed that Resident #1 did not hit her . Nurse A explained to the sister that Resident #1 said her hurts, and sister replied just continue to observe. On at 7:50 AM, Resident Service Director ( ) documented Resident #1 was trying to transfer to the couch from the wheelchair and missed the couch, slid on the floor and there were no apparent injuries. Resident #1 was assisted to her wheelchair and her sister, and the Nurse Practitioner was notified. On at 10:41 PM, Nurse A documented	A 025		

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	AL11969028	A. BUILDING: _____ B. WING _____	05/15/2024

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A 025	Continued From page 14 Resident #1 was sitting in her recliner chair while getting her bed ready and changing her. Resident #1 became very resistant and started pulling away. Resident #1's right _ got caught under her bed frame resulting in a large _____ with a moderate amount of _____ and pressure was applied. There was no documented evidence that 911 was called and that the facility notified the family and physician of the incident. On _____ at 7 AM, Nurse E documented Resident #1 returned from the hospital from the lower _ sliced from her bed frame. Resident #1 was given a _____ shot and new orders for _____ and _____ 2% _____. Follow up with the physician in 10 days. Nurse E placed wrap over the sharp area of the bed. On _____ at 3 PM, an interview with the Resident Service Director (_____) confirmed that Resident #1 was sent out to the emergency room to be evaluated and treated. 2. Resident #2's record review revealed an admission date of _____. The 1823 Health Assessment dated _____ listed medical history of multiple _____ of the _____, a subsequent encounter for _____ with routine healing, speech and language _____ following unspecified _____, an encounter for other orthopedic aftercare, _____, presence of _____ and severe protein calorie _____. Resident #2 ambulates by wheelchair with a _____ risk precaution. Resident #2 needs assistance with activities of daily living (ADLs) in ambulation, bathing, _____, grooming, toileting and	A 025		

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A 025	Continued From page 15 transferring and independent with eating. Resident #2 needs assistance with self-administration of medications. In further review, the facility notes documented between timeframe of three months [redacted], Resident #2 [redacted] seven (7) times with no interventions put in place as documented below: On [redacted] at 12:26 PM, Nurse G documented that at approximately 9:30 AM, Resident #2 was found on the floor. Resident #2 was sitting on her [redacted] with her [redacted] against her closet door and her [redacted] straight in front of her closet door. A [redacted] brace was placed on as ordered. Resident #2 stated she was trying to get out a shirt out of her closet and [redacted]. Resident #2 denied hitting her [redacted] and complained of no [redacted]. Resident #2 was able to stand up with assistance. Will continue to monitor. Notified family and physician. On [redacted] at 5:51 PM, Nurse A documented Resident #2 pressed her bathroom call bell. Nurse A found Resident #2 sitting on the floor in her bathroom, in front of the toilet. Resident #2 stated that she was trying to get on the toilet herself and started falling and then hit her bathroom call light. Resident #2 denied [redacted] and there were no injuries observed. Resident #2's wheelchair was collapsed and lying next to her. Resident #2 said the wheelchair did not hit her. There was no documented evidence that the family and physician were notified after this [redacted]. On [redacted] at 9:47 PM, Nurse A documented Resident #2 was found on the floor. She was lying on her [redacted], about a few steps from her bed. Observed a large [redacted] that was felt on	A 025		

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A 025	Continued From page 16 ... of ... (left side). Resident #2 complained of , . Vitals checked, normal. Resident #2 was saying the lights were hurting her ,... Call 911. Resident #2 was transferred to hospital and notified her son and physician. Resident #2 went to skilled nursing rehabilitation after hospitalization and was out of the community for one month. The facility did not document any follow up details while Resident #2 was in the hospital and rehabilitation after the . on ... . On ..... at 2:42 PM, Nurse F documented Resident #2 returned to the facility from skilled nursing rehabilitation. Vitals normal and Resident #2 denied , or discomfort. Will continue to monitor. On ..... at 3 PM, Nurse F documented that approximately at 2:50 PM Resident #2 was observed lying on her ... in front of her toilet in the bathroom in her apartment. Resident #2 stated that she was trying to get into her wheelchair and felt ,. Nurse F assessed for injuries, a ... to the right and no complaints of , and discomfort. The son and physician were notified. On ..... at 7:05 PM, Nurse A was called to Resident #2's room. Resident #2 was observed lying on the bathroom floor. A pool of ... under her . Resident #2 did not hit her pendent to ask for help. Resident #2 said she just had returned from activities. Denied , and Resident #2 could not explain how she .. Applied pressure to of and call 911. Resident #2 transferred to the hospital. Notified family and physician.	A 025		

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A 025	Continued From page 17 On at 8:07 AM, Nurse E documented Resident #2 returned from the hospital at 330 AM early morning and had an on the of her . . . . Resident #2 kept taking off her ⌣ it was still ⌣. Nurse E explained to Resident #2 to leave it on so it can stop ⌣. Resident #2 kept trying to get in and out of her bed on her own multiple times. Nurse E reminded Resident #2 that her gait was unsteady, and she may again, and she needs to use her pendent & wait for a staff to come help her. Resident #2 said okay. Will continue to monitor. On 1:51 PM, Nurse F documented that approximately at 7:40 AM this morning, Resident #2 was observed lying on her in her room. Resident #2 stated that she was okay and was trying to go to the bathroom. Resident #2 was assessed for injuries, none observed. Resident #2 was assisted to the bathroom and had a movement. Observed upon transferring from the bathroom, Resident #2 was holding her right , and not bearing ⌣ . The physician ordered a right , ⌣. Family notified. There were no facility notes that 911 was called for Resident #2 to transport to the hospital. On at 11:20 PM, Nurse A documented that Resident #2 returned to the facility at 7:15 PM by non-medical transportation. Resident #2 had a to the , bone. She can bear ⌣ as tolerated. Resident #2 refused her meal and ate snack foods from her room. Resident #2 had no complaints and had her pendant to push for assistance. On at 7:41 AM, Nurse F documented Resident #2 was found on the floor trying to walk	A 025		

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A 025	Continued From page 18 to the bathroom without her wheelchair and did not request assistance. Resident #2 denied hitting her [illegible], but she said her left [illegible] hurts. Nurse F ordered an [illegible]. Resident #2 was refusing to go to the emergency room. Vitals normal and her family and physician were notified. On [illegible] at 7:23 PM, Nurse A documented received the left [illegible], and [illegible], results. The left [illegible] has an acute [illegible] radial [illegible] with mild displacement. The [illegible], and [illegible] were negative. The Nurse Practioner requested Resident #2 to be sent to the hospital. There was no documented evidence that the family was notified of the left [illegible] and sent to the hospital. A review of the facility's incidents/accidents procedures I-160 with emergency care related policy. This document did list any assessment to determine the level of care required after the [illegible], no interventions listed and no service plans. This was not a valid [illegible] policy and procedures that meet the state of Florida regulations in an assisted living facility. (Photographic Evidence Obtained) On [illegible] at 5:40 PM, an interview with the Administrator confirmed the findings and further stated that he will develop a more detailed [illegible] policies and procedures for [illegible] risk residents. Class II	A 025		