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
	AL11969348	A. BUILDING: _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMBASSY BRANDON LLC	1320 OAKFIELD DR BRANDON, FL 33511

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A 000	Initial Comments A complaint investigation (#2024011062) in conjunction with a generator monitoring visit was conducted on at Embassy Brandon. Deficiencies were identified 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	A 025		

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A 025	Continued From page 1 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 interviews and record reviews, the Facility failed to provide care and supervison for residents accepted for admission, to include awareness of general health and safety for seven residents (Resident #1, Resident #7, Resident #8, Resident #9, Resident #10, Resident #11, and Resident #12) of seven residents on the facility's memory care unit with that resulted in injury. The lack of prevention intervention for the memory care residents placed all residents at risk for injury; and the Facility failed to maintain a written record, updated with significant changes to include notes for two (Resident #10 and Resident #12) of three residents reviewed in the	A 025		

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A 025	Continued From page 2 memory care unit. Findings Included: In a record review of the resident roster conducted on there were 39 residents in house in the memory care unit. In an interview conducted on at 10:45am Staff A was assigned to the memory care unit, they said that they needed more staff on the memory care unit and that someone was always falling. Additionally, they were unable to say how many residents were in the memory care unit. In an interview conducted on at 11:07am with Staff B working in the memory care unit, they said they needed more staff on the day shift as well as 2:00pm to 10:00pm shift, and that there were around "forty something" residents on the memory care unit. They said Resident #12 had overnight. Additionally, they said that if a resident and hit their , they were not to pick them up. In an interview conducted on at 11:15am with the Memory Care Director she said that Resident #1 walked independently but was always unsteady. She said the family's video showed Resident #1 had gotten up on the night of the incident, was unsteady and leaned to the left and hit her . She said the staff got her off the floor and to the couch and called 911. Furthermore, she said "they are not to move them if they hit their ." She said Resident #12 had and , was ordered, but she was unable to say if they had started with him yet.	A 025		

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A 025	Continued From page 3 Additionally, she was unable to find any written documentation of the from staff and said she had not yet entered a note on it in the electronic system. Furthermore, she said there were a lot of residents on the unit that were ambulatory, and staff had to be vigilant, so she tried to staff the unit with two to four staff on nights but preferred three to four due to acuity level. She said Resident #9 her , but she forgot why they thought she would , however she said she was always unsteady, and her would give out. For Resident #10 she said he his , but she could not find documentation of his from a month and a half ago but was not sure why it was never documented. She said there were "forty-four residents but a few are out" on the memory care unit. She said there were no individual risk assessments performed for residents in the facility and asked the surveyor at 11:26am "should we do those?". At 11:30am she said that if residents in the facility, they would get involved however, she said management would talk with , but not about the progress or plan for the residents being seen. In a record review of the 1823 Resident Health Assessment(1823) completed prior to the incident for Resident #10 conducted on he had a diagnosis of , a prior and , general , physical/sensory limitations, and precautions listed. In a record review of the 1823 for Resident #1 prior to the incident dated conducted on she had a diagnosis of 's and , and required supervision with ambulation, bathing, , self-care,	A 025		

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A 025	Continued From page 4 toileting and transferring. In a record review of the electronic notes for Resident #1 conducted on [redacted] there was a note dated [redacted] that said "Staff observed resident laying on the floor in her room. Staff noticed a [redacted] above left [redacted], a bump on left side of [redacted]. Resident was assisted to her couch. Basic first aid applied. 911 called. Resident transported to [local hospital]." In a record review of the 1823 dated [redacted] for Resident #12 conducted on [redacted] he had a diagnosis of difficulty walking, [redacted], unspecified [redacted], unspecified severity with agitation, [redacted], and required assist with activities of daily living and transfers. [redacted] status listed was "alert and oriented x 2 with [redacted]". He required assistance with ambulation, bathing, [redacted], toileting and transfers. In an interview with a family member for Resident #5 conducted on [redacted] at 11:47am they said the resident had [redacted] four times. Furthermore, they said they were not happy with care and staff would answer the phone on the unit, but put it down and never pick it up again. They felt the facility needed to make big changes in the memory care unit. In an interview with a family member for Resident #12 conducted on [redacted] at 11:52am they said the resident [redacted] because the bed rail was not up. In a record review of the facility adverse incident	A 025		

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A 025	Continued From page 5 reports for Residents in the memory care unit in the month of conducted on , the following were found: " Resident #1 on and sustained an orbital and . Staff C and Staff D listed on the report were both unlicensed personnel. " Resident #7 on and sustained a injury that required staples to the left side of her . " Resident #8 on and sustained a injury that required to his left . " Resident #9 on and sustained a ; had diagnoses listed of , , and required walker for mobility. " Resident #11 on and sustained a injury that required staples to the of her . In a review of the facility "Memory Care Daily Assignment Sheets" conducted on there were two staff on the memory care unit for the 10:00pm-6:00am shift on , and and only two staff were scheduled for 10:00pm-6:00am for , and . In an interview with the Administrator conducted on at 12:14pm she said the ratio in memory care was ten residents to one staff, but sometimes less. She said they would do , , , for residents with , but they did not do risk assessments and would go by whatever was on the 1823. She was unsure who was qualified to assess the residents before they were admitted. She said they had no plan for other than having residents evaluated by , but would find the risk form and add the	A 025		

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A 025	Continued From page 6 assessment to their evaluations and complete it after any . Additionally, she said she would need to look at staffing due to the level of residents in memory care. At 12:50pm she agreed the serious injuries in were too many. She said she asked the Memory Care Director to put up a hospital board so they would know who was out and which residents were in house. She said she would update 1823's with significant changes and do 72-hour charting after . She said they could have done things differently but would use this as an opportunity to improve care. Photo Evidence Obtained. Class II	A 025		