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
	AL11910672	A. BUILDING: _____ B. WING _____	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING FOREST TRACE	5500 NW 69TH AVENUE LAUDERHILL, FL 33319

(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 complaint survey 2024011401was conducted on at Pacifica Senior Living Forest Trace. The facility had deficiencies at the time of the visit.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician	A 010		

AHCA Form 3020-0001

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

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A 010	Continued From page 1 who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010		

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A 010	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within	A 010		

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A 010	Continued From page 3 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A _____, ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.	A 010		

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A 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a Resident Health Assessment 1823 form was completed upon significant change and reflective of the resident's current health status and care needs, for 2 of 2 sampled residents (Resident # 2 and #3) identified as a risks. The findings included: 1) Review of Resident #2's medical record revealed the resident was admitted on . Review of the resident's Admission Resident Health Assessment form 1823 dated indicated the medical diagnosis of , , ,

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A 010	Continued From page 5 investigation was conducted and discussion held with family regarding 24/7 PDA (Private Duty Aide) coverage to reduce risk. The 1823 form was not updated reflecting history and care implemented to reduce risk. 2) Review of Resident #3's medical record revealed the resident was admitted on . Review of the resident's current Admission Resident Health Assessment 1823 form dated indicated the medical diagnosis including 's exacerbation, and . The resident required assistance with bathing, , and transfers, and utilizes wheelchair and walker for ambulation. The 1823 form does not reflect any recommendation for precautions. The resident on admission was assessed as a high risk with a Morse score of 65, implement high risk prevention interventions. Review of Resident #3's history reveals a on , resident was unsteady, sustains and evaluated at hospital, with new diagnosis of 's . Resident#3 is prescribed new medication for 's and ordered , , , . Also, private duty aide 24/7 oversight was implemented. On , the resident is documented as sustaining a with no injury. On , the resident is documented as sustaining a and sent out to the hospital for evaluation. On , the resident is documented as falling and sustaining a injury. Review of the facility internal incident dated at 5:10AM Resident #3 was found in the bathtub with a , was observed by staff. 911 was called, the resident transferred to the hospital for evaluation and the	A 010		

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A 010	Continued From page 6 family was notified. Resident#3 returned to the facility at 7:06AM. The care plan was updated to remind the resident to use the call bell when needing to ambulate. In an interview with the current Resident Care Director (RCD), LPN on at approximately 3:00PM she stated a investigation was conducted and discussion conducted with family regarding 24/7 PDA coverage to reduce risk. The RCD stated that Resident#3 has had numerous , many with injury requiring transfer to the hospital for evaluation. The RCD reviewed the current 1823 form and confirmed the form does not reflect the resident's current status and care requirements for . Class III	A 010		
A 025	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	A 025		

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A 025	Continued From page 7 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 additional services.	A 025		

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A 025	Continued From page 8 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide the level of care, services and appropriate oversight required to meet the needs of the resident who had a change of condition. This was evidenced by the failure to document nursing care oversight for 3 of 3 sampled residents, Resident #1, #2 and #3 who had multiple with sustained injury requiring transfers to higher level of care for treatment and failure to update the care plan after . Additionally, the failure to monitor Resident#1 requiring continuous ( ) and bilevel positive airway pressure (BiPAP) use for changes in declining condition. The findings include: Review of Resident #1's medical record revealed the resident was admitted on . Review of the resident's Admission Resident Health Assessment form 1823 dated indicated the resident had medical history including . The resident was assessed to require supervision with bathing, and self-care. The assessment indicated the resident was at risk for . Review of Resident #1's 1823 form dated revealed the resident medical history including x2, 4 ( )/ 2nd degree with / , acute , failure- /2022 and . The assessment indicated that Resident #1 had an unsteady gate and required with ambulation. The resident was documented at " and . The updated 1823	A 025		

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A 025	Continued From page 9 form does not include precautions. Review of Resident #1's medical record nursing note dated revealed the resident's family member had taken the resident to the health care provider. Resident#1 was experiencing low ( ) saturation levels and (CO2) levels were elevated. The note revealed Resident#1 was admitted to the hospital for treatment. The resident is prescribed at 2 Liters (2L) /min. Further review indicated on , the resident returned to the facility. The resident's family contracts with a Home Health Agency for 24/7 private aides on , 2 shifts 8AM-8PM and 8PM- 8AM. Resident care responsibility to include -on support with ambulation, transfers and toileting. No further nursing documentation was available for review indicating nursing monitoring of , status after Resident #1's readmission on . Review of the facility staffing levels which reveals the facility employs a Resident Care Director who is a licensed nurse and has licensed nurses on duty daily. Review of Resident #1's medical record dated indicated the resident in the bathroom of her apartment at 5:10AM. The note indicated the resident had a Private Duty Aide (PDA) who was assisting the resident. The note further indicated that 911 was called and the resident was transported to the hospital for evaluation. The note indicated the family was notified of the incident.	A 025		

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A 025	Continued From page 10 Review of Resident#1's hospital record dated 5:49AM indicated the resident was admitted by ambulance. Resident#1 was noted as accidentally falling backward, missing the toilet seat and sustaining a , , . The record indicated no loss of or , but Resident #1 was noted to complain of . Vital signs were recorded as , , , 17 min, , reading on room air reading 90%. A was closed with staples. The record indicated that a computed (CT) scan of the was completed, and the resident was determined to have a small hematoma. Resident#1 was admitted to the hospital for observation. Discharge orders included return to physician office in 48 hours for check and staple removal in days. Resident#1 was discharged to the Assisted Living Facility (ALF) on at 5:15PM. In an interview with the current Resident Care Director (RCD), license practical nurse (LPN) on at approximately 3PM she stated that she was not employed during this incident and stated that she was unable to locate/provide any internal report showing an investigation of the event. She stated she was unable to locate an updated care plan reflecting any changes in care because of the . A review of Resident #1's home health agency (HHA) client notes conducted by Surveyor #A revealed the HHA had not been notified of the on and no investigation was conducted by the HHA. No additional nursing progress notes were found for 3PM-11PM and 7A-3PM shift	A 025		

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A 025	Continued From page 11 documenting nursing monitoring, checks for Resident #1 after the injury Review of Resident #1's nursing notes dated at 4PM indicated "resident was ok all shift no signs of distress. Staples dry and intact." No additional nursing progress notes were found for documenting monitoring Resident#1 after injury. Review of Resident#1's nursing notes dated at 4PM "resident is OK, no complaints, no signs of distress, staple of dry/ intact." No additional nursing progress notes were found for documenting monitoring Resident#1 after injury. No documentation was found for for resident monitoring . Review of Resident #1's nursing note dated indicated the resident went out with her family member to the physician for staple removal. No additional nursing progress notes were found for documenting monitoring of the , upon return. In an interview with family member of Resident #1 on at approximately 10:30AM revealed the resident was prescribed a bilevel positive airway pressure (BiPAP) medical device for ( ), and hypoxemic (low level of in the).The family member stated that Resident #1 wore the device primarily at night but struggled with comfort with its use. Definition of bilevel positive airway pressure (known as BiPAP) is a machine that helps a person breathe. It's a form of	A 025		

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A 025	Continued From page 12 that health care providers might use if the patient can breathe on their own but aren't getting enough or can't get rid of . Standard care recommendations with use of a BiPAP device include to monitor the patient for changes in and , including vital signs, saturation, breath sounds, breathing pattern and work of breathing. Review of Resident #1's nursing notes revealed the next note dated on at 10AM. The resident was brought to the nurse's station by the PDA.Resident#1 was assessed by the Licensed Practical Nurse (LPN) on duty to have 2 located on her left and left . The note indicated Resident#1 stated she on and the PDA picked her up, the resident could not say what caused the . Resident#1 complained of but refused to go to the hospital for evaluation. The LPN administered as ordered and informed the resident's family of the . Review of the note does not indicate if the physician was notified of the . Review of the Resident #1 medical record for reveals no documentation of any report given by the HHA PDA to the facility nurse regarding the that occurred. A review of Resident #1's home health agency (HHA) client notes conducted by Surveyor #A revealed the agency had not been notified of the on and no investigation was conducted by the HHA until . Review of facility Internal Incident Report for Resident #1 dated completed by the LPN and reviewed by the RCD (at that time) indicted a on , no time was noted on	A 025		

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A 025	Continued From page 13	A 025		

the report. The report revealed the nurse received report from PDA that the Resident#1 had 2 , one on her left and left , . The report further indicated the LPN notified the resident's family member on at 10:35AM, who stated he was unaware of the . The report indicted Resident#1 had refused to go to the hospital for evaluation. The note indicates the family and Resident#1 will discuss and decide about any evaluation plan. Further review of the report indicated follow-up action as "will follow up with resident and son."

Review of Resident #1's nursing note dated -3PM-11PM into 11PM-7AM shift indicated the "resident walked around her room all night and did not sleep at all per her PDA."

Review of Resident #1's nursing note dated 7AM-3PM shift indicated the resident complaining of left side , and was given ordered for , . Vital signs were taken, , , ( ) , , Temperature 97.1F. Further review of the note indicated no follow-up to assess resident's level of , after medication was administered.

Review of Resident #1's nursing note dated 3PM-11PM shift indicated the resident had no complaints or signs of distress.

Review of Resident #1's nursing note dated 7AM-3PM shift indicated the nurse spoke with resident's family member about resident's complaint of , , and a physician . . was made by the family.

Review of Resident #1's physician office visit note dated revealed resident was seen for " ". The physician note indicted on

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(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 14 Resident#1 was in her apartment when her walker slipped away from her. The note further indicated Resident#1 a 2nd time on while walking backward and she lost control of the walker. The note indicted Resident#1's left side is badly , and she cannot lift her left arm. The note indicated Resident#1 did not hit her and had no loss of with the . Resident#1 is noted to have been taking for . The note further indicates Resident#1 was positive for fatigue, ( ), lower extremity , gait imbalance and general . The note indicated Resident#1 requires a wheeled walker and standby guarding to prevent . The resident's vital signs reading was 114/63, , , , 24 and , ( ) 92 % on 2 liters/minute (2L/min) via . The note further indicated a large on Resident#1's left , . The note indicates a recommendation for close supervision with all ambulation, transfers with standby assistance with stability. An , of the resident's left and , was ordered. , was ordered every 8 hours for , with avoidance of due to risk and . In an interview with the current Resident Care Director (RCD), LPN on at approximately 3PM she stated that she was not employed during this incident and stated that she was unable to provide any internal incident report showing any investigation of the second event on . She stated she was unable to locate an updated care plan reflecting any changes in care. Review of Resident #1's nursing notes after revealed no documentation of a	A 025		

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	AL11910672	A. BUILDING: _____ B. WING _____	12/10/2024

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A 025	Continued From page 15 nursing assessment with health care provider recommendation orders after 3 days from the . Review of Resident #1's nursing note dated 7AM-3PM shift revealed resident complaint of , and inability to sleep on left side due to . Review of Resident #1's nursing note dated revealed on at 7:15AM the resident complained of ( ) while using . 911 was called and the resident was transferred to the hospital for evaluation. The note further indicated that the physician and family member were notified of the transfer. Review of Resident #1's hospital record dated indicated a complaint of left arm , . The report indicated Resident#1 is , and unable to provide meaningful history. The report indicated a family member was at bedside and reported that the resident twice. The physical exam revealed Resident#1 was , using , support (BiPAP) with decreased breath sounds on . A saturation reading recorded at exam was 89%. A computed (CT) scan of was ordered and revealed displaced left lateral 3rd through 5th along with displace to body of , along with several acute left , . Resident#1 was assessed and recommended to be admitted for , , and orthopedic consultations for acute ( ) exacerbation, acute hypoxic non-vent dependent , failure, on BIPAP, and multiple and . In an interview with the current Resident Care	A 025		

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A 025	Continued From page 16 Director (RCD), LPN on at approximately 3PM she stated that she was not employed during this incident and stated that she was unable to provide any internal incident report showing any investigation of the change in resident condition and transfer to higher level of care for evaluation. Review of Resident #1's nursing note dated 6PM indicated the resident returned from hospital. The resident was documented as alert and responsive and a new medication order for , , was received. Further review indicated no nursing note for 11PM-7AM shift, no , , assessment or monitoring was documented. Review of Resident #1's nursing notes indicated the next nursing note was on - 7AM-3PM shift. The note indicated Resident#1 had no complaints and vital signs were taken. There was no saturation reading recorded or nursing , , monitoring documented. There were no additional nursing notes for for review. Review of Resident #1's nursing note dated 10:15 AM indicated the resident was while on . Vital signs were taken, , , saturation reading 85%. The resident was sent 911 to the hospital for evaluation. The note does not indicate if the family or physician was notified with transfer. In an interview with the current Resident Care Director (RCD), LPN on at approximately 3PM she stated that she was not employed during this incident and stated that she was unable to provide any internal incident report	A 025		

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A 025	Continued From page 17 showing any investigation of the change in resident condition and transfer to higher level of care for evaluation. Review of Resident #1's nursing note dated at 12:46PM indicated the resident returned to the facility. The resident is assessed to have clear sounds but diminished and has a . The note indicated Resident#1 using 2L via . Vitals were recorded, no saturation reading was recorded. Review of Resident #1's nursing note dated 3PM-11PM shift indicated the "resident was OK, with no signs of distress". No further nursing monitoring for status was documented. Further review of nursing notes revealed no documentation of discussion with health care provider to monitor status for potential changes in condition. Review of Resident #1's 1823 form updated on revealed the resident's medical history including ( ), hypoxemic (low level of in the), failure, hypercapnia (too much in the) , , , , vision loss both , and mild to moderate . Nursing treatment requirements documented as needed assistance with medication administration, assistance with all ADLs and supervision with eating, ordered home for injuries from recent , and assisting walking. 2L and BIPAP use when sleeping, with PDA assistance to turn on and off. Special precautions included prevention. Review of Resident #1's nursing note dated	A 025		

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A 025	Continued From page 18 7:23PM indicated the nurse was called to the resident's room by the PDA. The PDA reports the resident was bending down to sit on the toilet and started to from her . The nurse documents observation of several large clots on the bathroom floor in front of the toilet. Resident#1 was transferred 911 to the hospital for evaluation and the family was notified. Review of Resident #1's nursing note dated indicated resident returned to facility after diagnostic tests were performed at the hospital. The note further indicated the resident left the hospital against medical advice and the family was aware. Review of Resident #1's nursing notes did not document nursing assessment after hospitalization for . Review of Resident #1's nursing note dated 5:09PM indicated the nurse was called to the resident's room, PDA reported the resident was not feeling well. The note indicated Resident #1 was , with vital sign readings of , , saturation of 65%. 911 was called and Resident#1 refused to be transferred to hospital. The note indicated the family was notified and resident remained in the facility. Further review of nursing notes indicated no documentation of nursing , , monitoring after complaint of . Review of Resident #1's nursing note dated indicated the resident is transported by the PDA to the nurse station for evaluation/ treatment of a left lower . The note indicated first aid was given and a message left	A 025		

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A 025	Continued From page 19 for family member. The note did not reflect if the physician was notified. Review of the medical record indicated no nursing documentation of status on was available for review. Review of Resident #1's nursing note dated indicated the resident was taken to her physician by the family. Resident #1 returned to the facility with an order and care order for left ⌄ . Review of Resident #1's nursing note dated indicated the resident had no complaints. New medication orders were given with no adverse effects. The note indicated the left ⌄ ⌄ was changed. No nursing documentation was made of observation of status or nursing care of . Review of Resident #1's nursing note dated indicated the nurse received report that on , the resident's PDA called for assistance for the resident due to ⌄. 911 was called but Resident #1 refused transfer to hospital for evaluation. Review of Resident #1's nursing note dated indicated the resident was assessed by the nurse, vital signs were taken, and no ⌄ was noted. The note did not reflect a saturation reading. Review of Service Plan Summary dated indicated a conference call between the resident's family member and the RCD regarding the facility emergency response protocol. The note indicated that the RCD informs the family member that 911 will be called in the	A 025		

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A 025	Continued From page 20 event of an emergency such as . The resident had refused transfer on for and on for , and change in condition, low , level. The document indicated that the family member informed that resident does not do well at hospital and prefers she not go to the hospital if she does not need to go. The note documents the family member requested to be called first prior to calling 911. The RCD is documented as informing family that the request is not the facility protocol and staff will follow facility policy to call 911 in an emergency, but the resident has the right to refuse treatment. Review of Resident #1's nursing note dated indicated the nurse and family member discussed a ( ) for the resident. The note indicated the family member was considering possible hospice admission. Review of Resident #1's nursing note dated indicated a hospice consultation was scheduled. Review of Resident #1's nursing note dated indicated resident was taken to hospital and admitted for fluid retention. Review of Resident #1's nursing notes prior to entry on indicated no documentation of any change in the resident's condition requiring medical evaluation. Review of Resident #1's hospital record dated indicated the resident was admitted for evaluation. The findings included acute hypoxemic , failure, secondary to exacerbation of ( ) vs (HF) vs Deep Thrombus ( ) vs , . The	A 025		

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A 025	Continued From page 21 resident is assessed to have increased and . The resident has an above the left ankle. The resident was placed on BiPAP and 40mg administered for fluid retention. The resident was discharged to the facility on with orders including change in settings, to 3L/ min by continuous and with BiPAP. Review of Resident #1's 1823 updated indicated the resident had mild to moderate , required assistance with all Activities of Daily Living (ADL) including ambulation. The resident required / BiPAP administration and monitoring. The resident required precautions. Review of Resident #1's nursing note dated indicated resident was observed weak. Vital signs were taken, no saturation reading was recorded. No further nursing notes or documentation was available for review from - . Review of the facility policy "Alert Charting" dated indicated Alert Charting will be implemented for residents who have had a recent change in their expected or customary function or other reason that initiates a need for closer monitoring. Alert charting will be initiated if a resident exhibits a change in condition; is returning from the hospital, emergency room; any other reason deemed appropriate by the RCD. Each resident placed on alert charting will be monitored for at least 48 hours. There is to be an alert charting entry in the resident record each shift. Care staff will immediately notify RCD or designee if resident is exhibiting a change of condition.	A 025		

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A 025	Continued From page 22 The next nursing note for Resident #1 available for review was on . Review of Resident #1's nursing note dated indicated around 9:40AM unlicensed staff #C went to the resident room to bring her morning medications. Staff #C observed Resident #1 sitting in her recliner chair with the PDA sitting next to her. Staff #C called out resident's name with no response. The note further indicated the PDA stated to Staff #C that the resident's family was on the way to the facility. The note indicated while Staff #C was in Resident #1's room, the family member arrived. The note further indicated that the family member stated that a call was received from the PDA indicating the resident was not doing well. The note indicated Resident#1 was not responding and the family member was refusing . The note indicated Staff #C exited the resident's room and called 911. In an interview with the current Resident Care Director (RCD), LPN and current Executive Director on at approximately 3PM, both stated that they were not employed during this incident. They stated they were unaware if an investigation was conducted and could not provide an internal incident report showing any investigation of the change in the resident's condition and . A review of AHCA Surveyor #A and B 's prior survey documentation was conducted, and a timeline was recreated of events occurring on based on the surveyors' findings from interviews and record review. The following is a consolidated timeline for the incidents occurring on :	A 025		

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A 025	Continued From page 23 Resident #1 was in her apartment- #281 being cared for by Home Health Agency (HHA) PDA #A, who works from 8PM-8AM shift. Review of the facility "ZONE Activity Report' dated on for Apartment #281 indicated that the check in "light "was activated a total of 8 times: "Check-in received " noted at 12:56AM, 1:24AM,1:47AM, 2:41AM, 5:57AM, 7:53AM, 8:02AM and 8:04AM. The report indicated no documented "emergency calls" were recorded on the system's written report. Review of the Emergency call system, "Silversphere Companion One" manual indicated the "Staff Check" feature is designed to remind staff and enforce scheduled times for residents to be checked. The manual further indicated that when the "check mark" button on the device is depressed, the system shows "staff in room" and room number on the telephone console. This disables clearable alarms from the room while care is being performed. When care is completed, staff press the "check mark" button again to re-enable alarms. Further review of the "Silversphere" Troubleshooting Guide, page 5 indicated "Check-In Received" code is the message displayed on the console when the check-in button on the call-station is pressed provided check-in is enabled and the message has been configured to appear on the console. The "Emergency Call" message is displayed when a station is activated, if its associated code is assigned to the emergency call event in programming. In an interview with family member of Resident #1 on at approximately 10:30AM he stated that PDA#A had reported she pulled the emergency cord at 2AM and 6AM.	A 025		

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A 025	Continued From page 24 Review of a signed written statement by facility Staff #B on who was duty on . - revealed she made rounds, checking and found Resident#1 asleep at around 1AM. She documents she checked on Resident#1 around 3AM and found the resident asleep. At 6AM, the resident was in bed per the statement of Staff #B. Review of an interview with Staff #B on 3:13 PM by Surveyor #B she stated that she works the 11PM-7AM shift. She stated that she had worked on and was assigned Resident #1. She stated she went into Resident #1's room when she came on duty at 11AM (possible typo) and the resident was "fine, with no problems.". Staff #B stated she went to check on the resident again at 1AM and found the resident asleep and breathing. At 3AM and 5AM the resident was "still fine per PDA". Staff #B stated that she checks on residents every 2 hours. When asked if the emergency pull cord was pulled during her shift, she stated no. She informed Surveyor #B that she had activated the button 4 times, which means she entered the resident's room to check on the resident and provide , care since the resident was wearing pullup briefs. Staff #B stated the resident was not wet, she was sleeping and breathing. She stated she left work at 7AM. 7:52AM- 7:56AM Resident #1's family member makes a call to the resident. PDA#A reports that the resident is unsteady, and had not consistently utilized the BIPAP device during the night. The PDA informs that she would stay over her shift end time to assist PDA#B with , the resident. The family member instructed PDA#A to encourage	A 025		

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A 025	Continued From page 25 Resident#1 to use the BIPAP during day. 7:53AM, 8:02AM and 8:04AM Check -in signal activated per written check-in ZONE Activity Report dated , no documented "emergency calls" were recorded on the system written report. 7:59AM -8:00AM Reported by PDA#A Resident #1 takes her own , , and the readings are recorded in a private log by PDA #A, readings left arm, , right arm. 8:14 AM BIPAP machine is unplugged per family member based on medical device internal log record. 8:15AM Resident is re-connected to BIPAP device per family member based on medical device internal log record. During an interview with Surveyor #A on at 10:41AM, the family member stated the PDAs, PDA #A and oncoming day shift PDA #B were instructed to transfer Resident#1 from the wheelchair to the recliner chair and attached the BiPAP device to the resident. 8:28AM Alleged call made from Resident #1's room phone to front desk by PDA#A Review of a signed written statement by facility Staff #A documents on " she was on duty and about 8:25AM she went to check on Resident #1 in . Staff #A documents she observed 2 PDAs working with Resident#1, one was making the bed on the right side and the other PDA was caring for the resident who was on the toilet. Staff #A pressed the button and	A 025		

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A 025	Continued From page 26 exited the room. Further review of the facility Zone Activity Report for revealed no check-in received /recorded at that time. The staff does not document if the PDAs informed her of the prior emergency calls for assistance. 8:38-8:45AM Family member reported phone call from PDA #A from Resident #1's land line, PDA #B attempted to take Resident's , the readings were "very" low, , 27, saturation of 81%. The family member informs PDA #A of arrival in 30 minutes. Per family member, PDA#A did not indicate any sense of urgency to arrive sooner. PDA#A reports to family member that the facility emergency call system was pulled 3 times and a call place to front desk with the change in resident's condition and requesting assistance. 9AM During an interview on at approximately 11:30AM with family member, stated the BIPAP device manufacturer's internal log indicated at 9AM, the device defaulted to an automatic , , cycle setting of 4 breaths /minute. 9:21 AM During an interview with the family member indicated that a call was made to the resident's apartment phone at 9:21AM on . PDA #B was advised of family arrival in 10 minutes. PDA#B informs the family that the resident is asleep. 9:30AM The family member arrival at the facility. While entering the building met PDA #A in the hallway as she was leaving. PDA#A was questioned by the family member if there had been a response	A 025		

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A 025	Continued From page 27 to the calls for assistance and the status of the resident. The family member stated that PDA#A advised that no facility staff had responded, and Resident#1 was sleeping. PDA #A and PDA #B both were in Resident #1's room from 8:00AM until 9:30AM when the family member arrived at the facility. During this time PDA#B goes to facility dining room to pick up a breakfast tray for resident. Review of the available documentation revealed that neither of the 2 PDAs made any additional efforts to alert facility staff that they required assistance for a significant change in Resident #1's medical condition beginning at 7:59AM. 9:30AM Staff #C positioned in front of dining room dispensing medications to other residents. 9:35 AM The family member arrived at Resident #1's apartment at 9:35 AM and found PDA #B seated at the kitchen table, the resident was sitting in the recliner chair with her elevated and BiPAP device attached. The family member stated Resident#1 looked like she was asleep, an attempt was made to take an saturation reading with the , as well as a check, both showed no readings. The family member stated he observed the BiPAP machine, and it was showing/reading 4 breaths/minute. He stated Resident #1 was to touch. 9:40AM The family member stated that at 9:40AM, Staff #C arrives to give Resident #1 her morning medications. The family member stated Staff #C stated "Resident is not breathing, I'm calling 911".	A 025		

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(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 28 The family member stated Staff #C did not approach or touch the resident to assess for a , . Staff #C announced she was going to call 911 and left the apartment. 9:42AM The family member stated the Resident Care Director, a Registered Nurse, arrived at approximately 9:42AM and assessed Resident#1, checking for the , and offered to start , , , , ( ). Review of reports show the family member declined since the resident was not breathing and because the resident, family and physician had discussed hospice admission and ( ) earlier that week after a hospitalization on . 9:42AM Fire Department Call to Service Report revealed the 911 call was received at 9:42AM, EMT personnel were dispatched at 9:44AM. 9:51AM EMT arrival at the facility. Resident #1 was assessed by EMT personnel, finding the resident , and not breathing. Resident#1 was pronounced at 9:58AM. The certificate reflects a time of as 8:30AM as reported to the emergency personnel by PDA#A as last time the resident was seen breathing. In an interview with the current Resident Care Director (RCD), LPN and Executive Director on at approximately 3PM, both stated that they were not employed during this incident. They stated they were unaware if an investigation was conducted and could not provide an internal incident report showing any investigation of the change in the resident's condition and .	A 025		

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	AL11910672	A. BUILDING: _____ B. WING _____	12/10/2024

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A 025	Continued From page 29 Review of Resident #1's apartment phone record provided by the family member revealed an outgoing call to number, 954-572-1800 at 12:28:38 ConnDateTime (UTC) (times expressed in military time as HH:MM:SS) for 23 seconds and again at 12:37:49(UTC) for 0.05 seconds. The number dialed is the facility's front reception desk. An additional outgoing call was made to the family member phone number at 12:38:35(UTC) for 7:03. Review of an interview with Front Desk Receptionist on at 2 PM, Surveyor #A asked what is the facility protocol when the emergency pull cord is pulled in the resident's apartment bedroom/ bathroom. The receptionist stated the calls go to the front desk when the pull cord is pulled. The Front desk staff will notify the facility staff member via walkie talkie of the emergency call. She stated the staff will respond immediately unless they are busy with another resident. She said the front desk is staffed around the clock. In an interview by Surveyor with the Front Desk Receptionist on at approximately 10:30AM she stated that she routinely attends daily morning management meeting which starts at 9AM. She stated on she did not receive any emergency calls from Resident #1's room before 9AM. She stated that another employee covers the front desk while she attends the meeting. She stated she recalled during the meeting that the past RCD received a text/ call to go to Resident #1's room for an emergency. The surveyor observed several white call box devices on the front desk. The surveyor asked the Front Desk Receptionist to describe the facility call device box. (See photographic evidence.) The Receptionist stated that the residents in the	A 025		

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A 025	Continued From page 30 Assisted Living section of the facility "are alert and are well aware of how to use the device to get assistance." She stated that the facility staff are also aware of how the call box works. She stated that Resident #1 had pulled the emergency cord numerous times to request assistance. The Receptionist held the call box device in her and stated in an emergency, the resident/ staff pull down on the "string" which activates an emergency call to the front desk. She stated that the incoming call will illuminate lights and chime on the front desk phone. She stated she would immediately call the facility staff on the walkie talkie to alert them of the call. She stated that many residents pull the emergency cord for everyday questions, non-emergencies. She was questioned about the " red check" button noted on the front of the device, and she stated that the button was used solely by the facility staff, it did not activate an emergency call in the system. She stated that the facility internal policy requires that daily between 6AM-10AM, the staff or resident must push the "check" button to indicate the resident was observed and OK. She provided a list of resident names and times when the "check" was pushed for that day. She stated that all staff including PDAs were aware that during an emergency, the pull cord was to be pulled and not to press the "check" button. Review of an interview conducted by Surveyor #B on at 1:31 PM with the facility Front Desk Receptionist, she stated that on prior to 9AM she did not receive any calls from Resident #1's room. She stated that the facility management team was having the regular morning meeting, starts at 9AM and she was in attendance. She stated that another facility employee was covering the desk, while she was attending the meeting. She stated that a call was	A 025		

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A 025	Continued From page 31 received at the desk after 9AM from someone in the Resident #1's room requesting to speak with the RCD. The Front Desk Receptionist stated that during the meeting the RCD received an "emergency text "to go to Resident #1's room and the RCD left the meeting immediately. Review of an interview conducted by Surveyor #B on at 2:05 PM with the employee covering the front desk on starting at 8:30AM, she stated that she did not recall receiving any emergency calls that morning regarding Resident #1. Review of an interview with Surveyor #A on at 2:55 PM, with unlicensed staff #C stated she gave medications to Resident#1 routinely in the hallway near the dining room at around 9:30AM or 10 AM. On the morning of , Staff #C said she was waiting downstairs until 9:30AM passing medications to other residents when she did not see Resident #1 at breakfast as she did most mornings, Staff #C went to Resident #1's # at 9:40AM. Staff #C stated that she had not seen Resident #1 prior to that time and upon entering the resident's room, she observed the resident sitting in her recliner chair and the PDA #B sitting next to the resident. Staff #C stated that the PDA informed her that the family had been called since the resident was not doing well. Staff #C stated that she questioned the PDA why she had not informed the facility staff, and the PDA responded that the resident's family requested to be called first. Staff #C stated that she did not have a cell phone, only the facility walkie talkie and left the room to call another coworker to notify RCD of the resident's condition. Staff #C was questioned by the surveyor, why there was no phone available to call 911 and if she had asked the	A 025		

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A 025	Continued From page 32 PDA, or family member to use the phone. Staff #C stated that she exited the room to text the RCD of the resident's condition and need for assistance. The RCD came within a few minutes to the resident's room. Staff #C stated that she did not call 911 prior to texting since she had to gather paperwork needed for the resident. Review of a written statement made by Staff #C dated and signed by Staff #C documented that "as she was checking the resident, the family member walked into the resident's room and refused a , check of the resident." Staff #C documented she informed the family member "she was going to call 911 and was told not to call, doesn't want resident to go to hospital." Staff #C writes she stated, "she must follow protocol and call 911" and called her supervisor and co-worker for assistance. Review of an interview with Surveyor #A on at 4:12 PM the (past) RCD stated that she routinely works 9:30AM-5PM daily. She stated she was familiar with Resident #1's care needs, the resident was , dependent and a full code status. The RCD stated that she was unaware that the resident's PDAs were recording the resident's , readings taken from the Resident #1's own , and , machines. She stated that resident vital signs are only monitored with physician order and Resident #1 had no orders. She stated that the resident had her own cuff and , in her room. The RCD stated the facility was not responsible for any , care needs or , readings or BIPAP machine without a physician's order. She stated that Resident #1 was independent with her , administration along with the assistance	A 025		

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A 025	Continued From page 33	A 025		

of private home health agency aides. She stated that the facility does not have any additional licenses for , , care. Additionally, she stated that the facility has no skills check list/competencies to measure unlicensed facility staff or 3rd party provider staff knowledge. The RCD stated that the aides are not permitted to document in the resident medical records, they are to verbally communicate any concerns with the nurse on duty. The RCD stated that on at 9:42 AM, she received a phone call from Staff #C concerned with Resident#1. The RCD stated she ran to the resident's room and found Resident #1 sitting in a recliner chair, her were elevated, and was in place. She stated the resident was unresponsive, had no , or , . The RCD attempted to place the resident on the floor to begin , but the resident's family member instructed her to stop. The RCD stated 911 arrived a few minutes after at 9:45 AM. The RCD stated the resident's family member expressed wishes to do not start efforts to EMT personnel. The RCD was asked about the facility protocol when vital sign readings are abnormal/ low -high, the RCD stated that the facility would first call the physician to get orders if critically low/high then they would call 911.

A computerized record was submitted by the family member for Resident #1's Log "Download" for , reveals on 7:59AM the Resident#1's was , taken by the resident, and , . At 8:02AM, a second reading was taken and , .

Review of an interview with Surveyor #B on at 4:33PM with the facility caregiver #A assigned to Resident #1 on . The care giver stated that on the morning of she

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A 025	Continued From page 34 was assigned to work with Resident #1, but she went to the Memory Care unit since she wasn't' sure of her assignment. She stated she remained on the Memory Care Unit for about 1 hour then went to check on her assigned residents. She stated she stopped at another resident room from 8:30-8:40AM then went to see Resident #1 at 8:40AM. She stated that Resident #1 was being care for by her PDA at that time, the resident was awake, her , were open, and she was breathing. She stated that she heard the resident had even before she went to check on her at 9AM. At that time, she observed police in the lobby and the PDA informed her that Resident #1 had , , . Review of an interview on at 5:15PM conducted by Surveyor #B with the Executive Director (ED), employed on , he stated that if there is an emergency, 911 would be called. He stated that if the resident has a PDA and there is an emergency, then it is the responsibility of the facility to provide the resident care. The ED stated that it is the facility expectation that the PDA would either pull the emergency cord or call the front desk, if the resident was incapable to do so. The ED stated that the facility does not rely on the PDA to provide any care status. He stated the PDA was hired by and care responsibilities determined by the family. He stated that the PDAs are hired to sit with the resident, take resident to meals, take the resident outside, the PDA is not responsible for "other" type of care. On at 5:16 PM during the interview with the ED stated there were no cameras at the facility South Tower elevator. In an interview on at 5:28PM, the ED stated that there was a South Tower elevator camera, no cameras on the upper resident floors and video would not be archived over 30	A 025		

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A 025	Continued From page 35 days. The ED stated that to his knowledge PDA #A did not report a medical emergency to him or his staff and does not believe the PDA reported it. He stated that there were 2 PDAs in Resident #1's room for over 30 minutes. He stated that the ALF staff was not called to the room until after the resident's son had been called and was on his way to the facility. The ED stated that someone called the resident's son first per his instructions to staff. Review of an interview documented on at 4:03PM conducted by Surveyor #A with PDA #A she stated that on the morning of the resident needed to be repositioned in the bed at 2AM. The resident expressed fearfulness, and the PDA attempted to reassure the resident. PDA#A stated she pulled the emergency call cord, but no facility staff responded. The PDA#A stated she pulled the cord in the bedroom and the bathroom which also has an emergency pull device and the noted that the green light was illuminated, "nothing in the room to indicate it was pulled". PDA stated that resident sometimes takes off breathing device "wore it that night but not all night". PDA stated resident went to bed around 4:30AM, and got up around 6AM.PDA#A stated resident seemed ok, wasn't moving fast and took her own vital signs. PDA#A stated she dressed the resident to go down to breakfast but after calling downstairs thinking the resident may need to be transferred to the hospital, PDA#A changed resident into her nightgown stated she didn't think resident condition was urgent and thought when family arrived the resident would go to the hospital. PDA#A stated the family member called and the resident was still "doing ok". PDA #A stated that the family member did not want resident sent to hospital and that he was coming to facility. PDA#A was instructed to place BIPAP	A 025		

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A 025	Continued From page 36 on resident. Resident was moved to the recliner, PDA#A stated around 8:30AM, and the PDA describes assisting the resident who appears _ and slow getting dressed. PDA #A stated PDA #B went to get resident's breakfast tray. PDA #A stated no staff responded before she left the facility. She stated if there is a change in resident condition, she should call downstairs to nursing station to get help and facility staff always use radio to get assistance. She stated at around 7:30- 8:00AM she spoke to someone at the front desk, stated she requested help and needed someone to come check on the resident. Review of facility policy "Resident Alert Call System" dated indicated "The community is equipped with a resident alert call system. Community staff will respond to all activations of the resident alert call system. For the purposes of this policy, the emergency is defined as" potentially dangerous situation that calls for immediate action". The policy continues teach assisted living resident will be provided with an alert device in the event that assistance is needed. Alert devices include but not limited to walkie talkies, pagers, wall alarms and resident alert call systems. Resident alert call systems are for emergency use only. Use of the resident alert call system is intended for medical emergencies including but not limited to, resident has , experiencing or , experiencing , or has high . When the resident alert call system is activated a personal care assistant will respond. Staff may not be able to immediately respond to the resident alert call system activation. The responding care personal will evaluate and 911 called. Personal Care assistants will provide appropriate first aid as required. Should a resident be found on the floor, follow the Response Policy."	A 025		

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A 025	Continued From page 37 Review of the Resident #1 medical record for reveals no documentation of any report given by the HHA PDA to the facility nurse regarding change in condition for the resident. Review of facility policy "Home Health and Other Outside Agencies" dated reveals Home Health or outside agency services will be coordinated with the Community. Services being provided by the Home Health Agency will be addressed in the resident's service plan. The home health agency/ outside agency staff is expected to check-in with the RCD or designee when arriving at the facility and when leaving. Then visiting nurse or other professional should complete an Outside Agency Documentation form for each visit. The RCD reviews the forms each day to review services being provided, identified changes in condition and ensure prohibited conditions are not developing. In an interview with the current Resident Care Director (RCD), LPN and Administrator on at approximately 3PM, both stated that they were not employed during this incident on . They both stated that when a facility staff or 3rd party provider encounters a medical emergency, they are to pull the emergency pull cord and call the front desk for assistance. They stated that the facility staff respond and evaluate the resident. Staff will contact the 3rd party provider office if receiving care and notify /contact the physician and family. In an interview with the current Resident Care Director (RCD), LPN on at approximately 12:30PM she stated that all 3rd party provider staff are to report in at the front desk and then check in with her or her designee.	A 025		

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A 025	Continued From page 38 She stated that she expects the providers to report to her with any changes in resident condition/care. She indicated that she holds weekly care meetings with the home health agency care nurses and monthly meetings with hospice providers. She stated she had no documentation of the meetings, and the resident record is updated only with changes in condition. Review of available documentation revealed that there were 2 HHA PDAs caring for Resident #1 on between 8AM until approximately 9:30AM. Interviews conducted during previous surveys with the PDAs revealed that Resident #1had a change in the condition, the emergency call cord had been activated several times and the front desk called for assistance. The Agency surveyor was informed that there was no response from the facility staff on duty. Based on review of the available documentation, neither of the PDAs physically left the resident and made an attempt to alert the staff of concerns with Resident#1's decline in medical condition. 911 was called by facility staff on arrival to perform routine duties. 2. Review of Resident #2's medical record revealed the resident was admitted on . Review of the resident's Admission Resident Health Assessment form 1823 dated indicated the medical diagnosis of , history of , and unsteady gait. The resident was assessed as a high risk with a Morse score of 75, indicating to implement high risk prevention interventions. The resident required assistance with all Activities of Daily Living and used a walker for ambulation. Resident #2 lives with his wife in the apartment.	A 025		

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A 025	Continued From page 39 Review of the facility internal incident dated at 5:10AM the resident called front desk and staff responded to find the resident on the floor in his apartment. The resident was observed with a on his right arm. 911 was called and initially the resident refused transport to hospital for evaluation. The resident was transported to the hospital and return at 7:06AM. In an interview with the current Resident Care Director (RCD), LPN on at approximately 3:00PM, she stated a investigation was conducted and discussion with family regrading 24/7 PDA coverage to reduce risk. She stated that she does complete an Adverse Incident Report after transfer to higher level of care for evaluation/ treatment, it was the responsibility of the ED to complete the report. 3. Review of Resident #3's medical record revealed the resident was admitted on . Review of the resident's current Admission Resident Health Assessment form 1823 dated indicated the medical diagnosis including 's exacerbation, and . The resident required assistance with bathing, , and transfers, and utilizes wheelchair and walker for ambulation . The 1823 form does not reflect any recommendation for precautions. The resident on admission was assessed as a high risk with a Morse score of 65, implement high risk prevention interventions. Review of the facility internal incident dated at 5:10AM Resident #3 was found in the bathtub, with a and was	A 025		

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A 025	Continued From page 40 observed by staff. 911 was called, resident transferred to the hospital for evaluation and the family was notified. The resident returns to the facility at 7:06AM. care plan updated to remind resident to use call bell when need to ambulate. Review of Resident #3's history reveals a on , resident was unsteady, sustains and evaluated at hospital, with new diagnosis of 's . Resident#3 is prescribed new medication for 's and ordered , , . Also, private duty aide 24/7 oversight was implemented. On , the resident is documented as sustaining a with no injury. On , the resident is documented as sustaining a and sent out to the hospital for evaluation. On , the resident is documented as falling and sustaining a injury. Review of the resident's progress notes reveal no nursing monitoring after injury. Review of the facility policy "Alert Charting" dated indicated Alert Charting will be implemented for residents who have had a recent change in their expected or customary function or other reason that initiates a need for closer monitoring. Alert charting will be initiated if a resident exhibits a change in condition; is returning from the hospital, emergency room; any other reason deemed appropriate by the RCD. Each resident placed on alert charting will be monitored for at least 48 hours. There is to be an alert charting entry in the resident record each shift. Care staff will immediately notify RCD or designee if resident is exhibiting a change of condition.	A 025		

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(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 41 In an interview with the current Resident Care Director (RCD), LPN on at approximately 3:00PM, she stated a investigation was conducted and discussion with family regrading 24/7 PDA coverage to reduce risk. The RCD stated that Resident#3 has had numerous , many with injury requiring transfer to the hospital for evaluation. She stated the PDA hours have recently been reduced and facility is discussing options with family for discharge due to inability to meet the resident's needs and to prevent . Review of the facility policy " " dated states all residents are evaluated for risk and their service plan will be developed/ updated. The risk evaluation (Morse Scale) will be conducted by a licensed nurse or trained designee. Each resident evaluated on admission and Service Plan update. Each resident identified as risk will be addresses with recommended interventions included in the Service Plan. Each Service Plan will be reviewed and updated when a resident has: a first , 2 or more within 30 days, a with injury requiring medical intervention and change in condition. If a resident the personal care assistants are to notify the RCD or Med tech on duty. A brief overview will be conducted. The RCD or personal care assistants will call 911 when the resident has , exhibits a change in or obvious / significant . The resident's physician is contacted immediately for further instructions. The RCD or designee will notify resident's family ... For 48 hours after a the RCD or designee on each shift will monitor the resident and make a brief narrative charting entry. An internal Occurrence report will be completed and returned to the RCD for review. Complete any state incident reporting as required. The RCD	A 025		

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A 025	Continued From page 42 informs the physician of subsequent and instability and discusses any interventions for care, ie. medication review, . If a resident is falling frequently the RCD may need to request one-on-one care if resident is not responding to interventions. If continue, relocation may be necessary. The Executive Director is to be informed of residents with history. CLASS II	A 025		
A 031	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the ,	A 031		

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A 031	Continued From page 43 resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to	A 031		

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A 031	Continued From page 44 demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to coordinate with the third-party provider to facilitate the receipt of care and services to meet the resident ' s needs. This was evidenced by the failure to develop, implement and document the facility policy for the care coordination and oversight to 1 of 1 sampled residents, (Resident # 1) who had history of , , decline and history of . The findings include: Review of facility policy "Home Health and Other Outside Agencies" dated reveals Home Health or outside agency services will be coordinated with the Community. Services being provided by the Home Health Agency will be addressed in the resident's service plan. The home health agency/ outside agency staff is expected to check-in with the Resident Care Director (RCD) or designee when arriving at the facility and when leaving. Then visiting nurse or other professional should complete an Outside Agency Documentation form for each visit. The RCD reviews the forms each day to review services being provided, identified changes in condition and ensure prohibited conditions are not developing. Review of Resident #1's medical record revealed the resident was admitted on . Review of the resident's Admission Resident Health Assessment form 1823 dated indicated the resident had medical history including , , , , . The resident was assessed to require supervision with bathing,	A 031		

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A 031	Continued From page 45 ˬ and self-care. The assessment indicated the resident was at risk for . Review of Resident #1's 1823 form dated revealed the resident medical history including ˬ x2, 4 ˬ ˬ ˬ, ˬ ( ) / ˬ , 2nd degree with , / , , , acute , ˬ failure- /2022 and , . The assessment indicated that Resident #1 had unsteady gate and required ˬ with ambulation. The resident was documented at " and ˬ . The updated form does not include precautions. Review of Resident #1's medical record nursing note dated revealed the resident's family member had taken the resident to the health care provider. The resident was experiencing low ˬ ( ) saturation levels and cardon (CO2) levels were elevated. The note revealed the resident was admitted to the hospital for treatment. Further review indicated on the resident returns to the facility. The resident is prescribed at 2 liters/ minute (2L/min). The resident's family contracts with a Home Health Agency for 24/7 private aides on , 2 shifts 8AM-8PM and 8PM- 8AM. Resident care responsibility to include -on support with ambulation, transfers and toileting. No further facility nursing documentation was available for review indicating nursing monitoring of , ˬ status after Resident #1's readmission on . Review of the facility staffing reveals the facility	A 031		

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A 031	Continued From page 46	A 031		

has a Resident Care Director (RCD) who is a licensed nurse and scheduled licensed practice nurses, (LPN).

Review of Resident #1's medical record dated indicated the resident in the bathroom of her apartment at 5:10AM. The note indicated the resident had a Private Duty Aide (PDA) who was assisting the resident. The note further indicated that 911 was called and the resident was transported to the hospital for evaluation. The note further indicated the family was notified of the incident.

Review of Resident#1's hospital record dated 5:49AM indicated the resident was admitted by ambulance. Resident#1 was noted as accidentally falling backward, missing the toilet seat and sustaining a . The record indicated no loss of or . Resident #1 was noted to complain of . Vital signs were recorded as 17 min, reading on room air reading 90%. A was closed with staples. The record indicated that a computed (CT) scan of the was completed, and the resident was determined to have a small hematoma. Resident#1 was admitted to the hospital for observation. Discharge orders included return to physician office in 48 hours for check and staple removal in days. Resident#1 was discharged to the Assisted Living Facility (ALF) on at 5:15PM.

Review of Resident #1's nursing notes dated at 4PM indicated "resident was ok all shift no signs of distress. Staples dry and intact." No additional nursing progress notes were found

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A 031	Continued From page 47 for 3PM-11PM and 7A-3PM shift documenting nursing monitoring, checks for Resident #1 after the injury. Review of Resident#1's nursing notes dated at 4PM indicated same language as . No additional nursing progress notes were found for documenting monitoring Resident#1 after injury. Review of Resident #1's nursing note dated indicated the resident went out with her family member to the physician for staple removal. No additional nursing progress notes were found for documenting monitoring of the , upon return. A review of Resident #1's home health agency (HHA) client notes conducted by Surveyor #A revealed the agency had not been notified of the on and no investigation was conducted by the HHA. In an interview with the current Resident Care Director (RCD), LPN on at approximately 3PM she stated that she was not employed during this incident and stated that she was unable to locate/provide any internal report showing an investigation of the event. She stated she was unable to locate an updated care plan reflecting any changes in care because of the . In an interview with family member of Resident #1 on at approximately 10:30AM revealed the resident was prescribed a bilevel positive airway pressure (BiPAP) medical device	A 031		

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A 031	Continued From page 48 for ( ), and hypoxomic (low level of in the). The family member stated that Resident #1 wore the device at night but struggled with comfort with its use. The resident was taking her own daily , ( ) and readings. Review of Resident #1's nursing notes revealed the next note in record, dated on at 10AM. The resident was brought to the nurse's station by the PDA.Resident#1 was assessed by the Licensed Practical Nurse (LPN) on duty to have 2 located on her left and left , . The note indicated Resident#1 stated she on and the PDA picked her up, the resident could not say what caused the , Resident#1 complained of , but refused to go to the hospital for evaluation. The LPN administered as ordered and informed the resident's family of the . Review of the note does not indicate if the physician was notified of the . Review of facility Internal Incident Report for Resident #1 dated completed by the LPN and reviewed by the RCD (at that time) indicted a on , no time was noted on the report. The report revealed the nurse received report from PDA that the Resident#1 had 2 , one on her left and left , . The report further indicated the LPN notified the resident's family member at 10:35AM, who stated he was unaware of the . The report indicted Resident#1 had refused to go to the hospital for evaluation. The note indicates the family and Resident#1 will discuss and decide about any evaluation. Further review of the report indicated follow-up action as "will follow up with resident and son."	A 031		

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A 031	Continued From page 49 In an interview with family member of Resident #1 on at approximately 10:30AM he stated that the resident informed she had a second time on . The PDA on duty did not report the to the facility. A review of Resident #1's home health agency (HHA) client notes conducted by Surveyor #A revealed the HHA PDAs did not document any on - and no investigation was conducted by the HHA until . Review of Resident #1's nursing note dated 3PM-11PM into 11PM-7AM shift indicated the resident walked around her room all night and did not sleep at all per her PDA. Review of Resident #1's nursing note dated 7AM-3PM shift indicated the resident complaining of left side , and was given ordered for , . Vital signs were taken, readings , , Temperature 97.1F. Further review of the note indicated no follow-up to assess resident's level of , after medication was administered. Review of Resident #1's nursing note dated 3PM-11PM shift indicated the resident had no complaints or signs of distress. Review of Resident #1's nursing note dated 7AM-3PM shift indicated the nurse spoke with resident's family member about resident's complaint of , and a physician , , was made by the family. Review of Resident #1's physician office visit note dated revealed resident was seen for	A 031		

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A 031	Continued From page 50 " ". The physician note indicted on Resident#1 was in her apartment when she , and then a 2nd time on . The note indicted Resident#1's left side is badly , and she cannot lift her left arm. The note indicated Resident#1 had no loss of with the . The note further indicates Resident#1 was positive for fatigue, ( ), lower extremity , gait imbalance and general . The note indicates a recommendation for close supervision with all ambulation, transfers with standby assistance with stability to prevent . An of the resident's left and , was ordered. In an interview with the current Resident Care Director (RCD), LPN on at approximately 3PM she stated that she was not employed during this incident and stated that she was unable to provide any internal incident report showing any investigation of the second event on . She stated she was unable to locate an updated care plan reflecting any changes in care. Review of Resident #1's nursing notes after revealed no documentation of a nursing assessment with health care provider recommendation orders after the 3d . Review of Resident #1's nursing note dated 7AM-3PM shift revealed resident complaint of , and inability to sleep on left side due to . In an interview with family member of Resident #1 on at approximately 10:30AM he stated that on in a response to the he spoke with RCD about the coordination	A 031		

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A 031	Continued From page 51	A 031		

protocol for facility and HHA response to medical emergencies. The RCD informed him that in an emergency the PDA must call 911 and then inform the ALF due to possible long response time. The RCD informed the family member that she would set up a meeting with the HHA to discuss his concerns. The family member never received a response to actions taken. The family member stated at this time he instructed the PDAs to use the auto dialer on the phone in Resident #1's room.

Review of Resident #1's nursing note dated revealed on at 7:15AM the resident complained of ( ) while using . 911 was called and the resident was transferred to the hospital for evaluation. The note further indicated the physician and family member were notified of the transfer.

Review of Resident #1's hospital record dated indicated a complaint of left arm , . The report indicated Resident#1 is , and unable to provide meaningful history. The report indicated a family member was at bedside and reported that the resident twice. The physical exam revealed Resident#1 was , using , support (BiPAP) with decreased breath sounds on . A saturation reading recorded at exam was 89%. A of was ordered and revealed displaced left lateral 3rd through 5th along with displace to body of , along with several acute left , . Resident#1 was assessed and recommended to be admitted for , , and orthopedic consultations for acute ( ) exacerbation, acute hypoxic non-vent dependent , , failure, on BIPAP, and multiple and , .

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A 031	Continued From page 52 Review of Resident #1's nursing note dated 6PM indicated the resident returned from hospital. The resident was documented as alert and responsive and a new medication order for was received. Further review indicated no nursing note for 11PM-7AM shift, no assessment or monitoring documented. Review of Resident #1's nursing notes indicated the next nursing note was on - 7AM-3PM shift. The note indicated Resident#1 had no complaints and vital signs were taken. There was no saturation reading recorded or nursing monitoring documented. There were no additional nursing notes for for review. Review of Resident #1's nursing note dated 10:15 AM indicated the resident was while on . Vital signs were taken, , saturation of 85%. The resident was sent 911 to the hospital for evaluation. The note does not indicate if the family or physician was notified with transfer. In an interview with the current Resident Care Director (RCD), LPN on at approximately 3PM she stated that she was not employed during this incident and stated that she was unable to provide any internal incident report showing any investigation of the change in resident condition and transfer to higher level of care for evaluation. Review of Resident #1's nursing note dated at 12:46PM indicated the resident returned to the facility. The resident is assessed to have clear sounds but diminished	A 031		

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A 031	Continued From page 53 and has a . The note indicated Resident#1 using 2L via . Vitals were recorded, no saturation reading was recorded. Review of Resident #1's nursing note dated 3PM-11PM shift indicated the "resident was OK, with no signs of distress". No further nursing monitoring for , status was documented. Further review of nursing notes revealed no documentation of discussion with health care provider to monitor , status for potential changes in condition. Review of Resident #1's 1823 form updated on revealed the resident's medical history including ( ), hypoxomic (low level of in the), failure, hypercapnia (too much in the) , , , , , , , , , , , , vision loss both , and mild to moderate . Nursing treatment requirements documented as needed assistance with medication administration, assistance with all ADLs and supervision with eating, ordered home , for injuries from recent , and assisting walking. 2L and BIPAP when sleeping, with PDA assistance to turn on and off. Special precautions included prevention. Review of Resident #1's nursing note dated 7:23PM indicated the nurse was called to the resident's room by the PDA. The PDA reports the resident was bending down to sit on the toilet and started to from her . The nurse documents observation of several large clots on the bathroom floor in front of the toilet. Resident#1 was transferred 911 to the hospital for evaluation and the family was notified.	A 031		

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A 031	Continued From page 54 Review of Resident #1's nursing note dated indicated resident returned to facility after diagnostic tests were performed at the hospital. The note further indicated the resident left the hospital against medical advice and the family was aware. Review of Resident #1's nursing note dated 5:09PM indicated the nurse was called to the resident's room, PDA reported the resident was not feeling well. The note indicated Resident #1 was , with vital signs readings of saturation reading was 65%. 911 was called and Resident#1 refused to be transferred to hospital. The note indicated the family was notified and resident remained in the facility. Further review of nursing notes indicated no documentation of nursing , monitoring after complaint of . Review of Resident #1's nursing note dated indicated the resident is transported to the nurse station for evaluation/ treatment of a left lower . The note indicated first aid was given and a message left for family member. The note did not reflect if the physician was notified. Review of the medical record indicated no nursing documentation was available for review for . Review of Resident #1's nursing note dated indicated the resident was taken to her physician by the family. Resident #1 returned to the facility with an order and care order for . Review of Resident #1's nursing note dated	A 031		

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A 031	Continued From page 55 indicated the resident had no complaints. New medication orders given with no adverse effects. The note indicated the left was changed. No noted nursing documentation of observation of status. Further review of nursing notes indicated no documentation of nursing care of . Review of Resident #1's nursing note dated indicated nurse received report that on , the resident's PDA called for assistance for the resident due to . 911 was called but resident refused transfer to hospital for evaluation. Review of Resident #1's nursing note dated indicated the resident was assessed by nurse, vital signs taken and no was noted. The note did not reflect a saturation reading. Review of Service Plan Summary dated indicated a conference call between the resident's family member and the RCD regarding the facility emergency response protocol. The note indicated the RCD informs the family member that 911 will be called in the event of an emergency such as . The resident had refused transfer on for and on for and change in condition, low level. The document indicated the family member informed that resident does not do well at hospital and prefers she not go to the hospital if she does not need to go. The note documents the family member requested to be called first prior to calling 911. The RCD documented as informing family that the request is not the facility protocol and staff will follow facility policy to call 911 in an emergency, but the resident has the right to refuse treatment.	A 031		

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	AL11910672	A. BUILDING: _____ B. WING _____	12/10/2024

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A 031	Continued From page 56 Review of Resident #1's nursing note dated indicated the nurse and family member discussed obtaining a ( ) for the resident. The note indicated the family member would be considering possible hospice admission. Review of Resident #1's nursing note dated indicated a hospice consultation was scheduled. Review of Resident #1's nursing note dated indicated resident was taken to hospital and admitted for fluid retention. Review of Resident #1's nursing notes prior to entry on indicated no documentation of any decline or change in the resident's condition requiring medical evaluation. Review of Resident #1's hospital record dated indicated the resident was admitted for evaluation. The findings included acute hypoxemic , failure, secondary to exacerbation of ( ) vs (HF) vs Deep Thrombus ( ) vs . The resident is assessed to have increased and . The resident has an above the left ankle. The resident was placed on BiPAP and 40mg administered for fluid retention. The resident was discharged to the facility on with orders including change in settings, to 3L/ min by continuous and with BiPAP. Review of Resident #1's 1823 updated indicated the resident had mild to moderate , required assistance with all Activities of Daily Living (ADL) including ambulation. The resident required / BiPAP administration	A 031		

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A 031	Continued From page 57 and monitoring. The resident required precautions. Review of Resident #1's nursing note dated indicated resident was observed weak. Vital signs were taken, no saturation reading was recorded. No further nursing notes or documentation was available for review from - . Review of the facility policy "Alert Charting" dated indicated Alert Charting will be implemented for residents who have had a recent change in their expected or customary function or other reason that initiates a need for closer monitoring. Alert charting will be initiated if a resident exhibits a change in condition; is returning from the hospital, emergency room; any other reason deemed appropriate by the RCD. Each resident placed on alert charting will be monitored for at least 48 hours. There is to be an alert charting entry in the resident record each shift. Care staff will immediately notify RCD or designee if resident is exhibiting a change of condition. The next nursing note for Resident #1 available for review was on . Review of the Resident #1 medical record for reveals no documentation of any report given by the HHA PDA to the facility nurse regarding a change in condition for the resident and subsequent on . Review of facility policy "Home Health and Other Outside Agencies" dated reveals Home Health or outside agency services will be coordinated with the Community. Services being provided by the Home Health Agency will be	A 031		

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A 031	Continued From page 58 addressed in the resident's service plan. The home health agency/ outside agency staff is expected to check-in with the RCD or designee when arriving at the facility and when leaving. Then visiting nurse or other professional should complete an Outside Agency Documentation form for each visit. The RCD reviews the forms each day to review services being provided, identified changes in condition and ensure prohibited conditions are not developing. In an interview with the current Resident Care Director (RCD), LPN on at approximately 12:30PM she stated that all 3rd party provider staff are to report in at the front desk and then check in with her or her designee. She stated that she expects the providers to report to her with any changes in resident condition/care. She indicated that she holds weekly care meetings with the home health agency care nurses and monthly meetings with hospice providers. She stated she had no documentation of the meetings, and that the resident record is updated only with changes in condition. In an interview with the current Resident Care Director (RCD), LPN and Executive Director on at approximately 3PM, both stated that they were not employed during the incident on involving Resident #1. They both stated that when a facility staff or 3rd party provider encounters a medical emergency, they are to pull the emergency pull cord and call the front desk for assistance. If no response, call 911. Refer to A 0025 Supervision Class II	A 031		

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A 165	Continued From page 59	A 165		
A 165	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse	A 165		

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A 165	Continued From page 60 incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a	A 165		

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A 165	Continued From page 61 licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to file an adverse incident report with the Agency after 3 of 3 sampled residents (Residents # 1, #2 and #3) were transferred to a more acute care setting for evaluation of injuries resulting from in the facility and failure to file a report for of Resident #1 at the facility. The findings include:: a) A review of hospital records and the facility ' s resident record revealed that Resident # 1 on , and and sustained injury requiring hospital care. A review of the facility ' s resident record revealed that Resident # 1 at the facility on . A review of the Agency's Incident Report Database revealed that no Adverse Incident Report was filed regarding Resident #1's transfer to a higher level of care for on , and . Additionally, no Adverse Incident Report was filed for Resident#1's at the facility.	A 165		

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A 165	Continued From page 62 b) A review of facility ' s resident record revealed that Resident # 2 and transferred to the hospital for evaluation of injury sustained with on . A review of the Agency's Incident Report Database revealed that no Adverse Incident Report was filed regarding Resident #2's transfer to a higher level of care for evaluation after on . c) A review of the facility ' s resident record revealed that Resident # 3 on , , , and and was transferred numerous times to the hospital for evaluation of injury sustained with . A review of the Agency's Incident Report Database revealed that no Adverse Incident Reports was filed regarding Resident #3's transfer to a higher level of care for evaluation after . On at approximately 12:45PM, the previous Executive Director of the facility confirmed by phone that no Adverse Incident Reports had been filed for Resident #1 for , requiring transfer to higher level of care. Additionally, no Adverse Incident Report was filed for Resident#1's at the facility. . On at approximately 12:30PM, the current Executive Director confirmed that no Adverse Incident Reports had been filed for Resident #1, #2 and #3 for , requiring transfer to higher level of care. Additionally, no Adverse Incident Report was filed for Resident#1's at the facility. The facility has not maintained Adverse Incidents Reports as required by 429.23 F.S., this practice	A 165		

Agency for Health Care Administration

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A 165	Continued From page 63 is ongoing. Refer to A 0025 CLASS II	A 165		