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
	AL11969236	A. BUILDING: _____ B. WING _____	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DISCOVERY COMMONS CYPRESS POINT	6870 ALISTER WAY FORT MYERS, FL 33912

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A 000	Initial Comments An unannounced complaint survey for # 2025000124 & 2025000668 was conducted on through at Discovery Commons at Cypress Cove, an assisted living facility in Fort Myers, Florida. Complaint # 2025000124 was substantiated at A 0165. Complaint # 2025000668 was substantiated at A 0083, A 0162, A 0025 at Class III, and A 0076 at class I level. The following is the description of the deficiencies. .	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the	A 025		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 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. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure residents at risk of were identified and staff were aware and able to identify risk potential for 3 (Residents #1, #5,	A 025		

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A 025	Continued From page 2 and #6) of 3 residents reviewed for multiple and transferred for evaluation at a higher level of care. The findings included: Facility policy titled CL15- . Policy date . . . . Policy: All residents are evaluated for risk and their Service Plan will be developed/updated accordingly. Should a resident experience a , staff will provide immediate care and follow through with service planning. . . . Procedure: 1. A. The risk evaluation: The risk evaluation (Morse Scale) will be conducted by a licensed nurse or trained designee. 1. C. Each residents's service plan and risk evaluation (Morse Scale) will be reviewed and updated whenever a resident has: i. a first (no prior documented/reported), ii. Two or more within thirty (30) days, iii. A with major injury requiring medical intervention/treatment, . A change in condition. 1. On a review of the facility Incident Log revealed Resident #1 had 3 in , , and . Review of Resident #1's chart revealed she was moved to the memory care unit on due to increased and agitative behaviors. Progress note on indicated Resident #1 was found on the floor around 7:45 p.m. with no apparent injuries. Progress note on indicated at 1:10 a.m., Resident #1 was on the floor in her room with no apparent injury. Progress note dated indicated that at 10:53 a.m. Resident #1 was found on the floor in the hallway. She was laying on her , and her walker was beside her. She said her right arm and right hurts. 911 was called and	A 025		

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A 025	Continued From page 3 Resident #1 was transported to the hospital. Progress note dated indicated staff had spoke with resident #1's daughter on the phone who stated Resident #1 was in surgery and her bone was broken from her right , to her right . Resident #1 never returned to the facility. Resident #1's Health Assessment Form 1823 (1823) dated indicated Resident #1 was a risk. Resident #1's service plan indicated she required safety checks every hours. A mobility risk assessment had been completed for Resident #1 on , but did not indicate whether Resident #1 was a low, medium or high risk for . No Morse Scale was found in Resident #1's chart. 2. On a review of the facility Incident Log revealed Resident #5 had 6 in the previous 30 days, on , , , , and . Review of Resident #5's chart revealed he lived on the assisted living side of the building and progress notes indicated the following: Progress Note dated indicated Resident #5 was observed on the floor next to his bed on his bottom with his , wrapped in the comforter. Resident #5 stated he tried to get up on his own and . Resident #5 denied hitting his or , no injury noted at that time. Resident #5 refused evaluation at hospital. Progress Note dated indicated Resident #5 had a around 3:25 a.m. Resident #5 was observed on the floor next to his bed with a small to the Right . Progress Note dated indicated Resident #5 was observed on the floor alert and oriented able to voice needs, with no , or discomfort noted. Resident #5 said he was trying to get up from the bed, he lost balance and .	A 025		

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A 025	Continued From page 4 Progress Note dated indicated Resident #5 was observed in his room next to his bed in a sitting position with his resting against the bed. Resident #5 said he missed the bed, no injuries were voiced or noted. Progress Note dated indicated at 7:00 a.m. Resident #5 was noted to have slid off the side of his bed onto the floor and was observed in a sitting position, he denied any , or discomfort. Progress Note dated indicated Resident #5 was found on the floor, on his , in front of the refrigerator. He said that he hit the of his . 911 was called and Resident #5 was sent to the hospital. As of , Resident #5 has not returned to the facility. Resident #5's Health Assessment Form 1823 (1823) dated indicated Resident #5 had a history of . Resident #5's service plan indicated he required safety checks every hours. A mobility risk assessment had been completed for Resident #5 on , but did not indicate whether Resident #5 was a low, medium or high risk for . No Morse Scale was found in Resident #5's chart. 3. On a review of the facility Incident Log revealed Resident #6 had 8 in the previous 30 days, on , , , , , , , , and . Review of Resident #6's chart revealed he was a memory care resident and progress notes indicated the following: Progress Note dated indicated Resident #6 was found lying on the floor next to his bed at 12:10 a.m. No injuries were noted Progress Note dated indicated Resident #6 was heard calling for help and found sitting on the floor in the bathroom. Resident #6 he said he and asked to help get him up. Resident #6	A 025		

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A 025	Continued From page 5 had a to his left arm. Progress Note indicated Resident #6 was found in a sitting position on the floor in the bathroom. He was helped off the floor and a small noted on his left . Progress Note indicated Resident #6 was observed on the floor by the care giver, alert and oriented with , he was unable to explain the due to , and no , or discomfort was noted by nurse. Progress Note indicated Resident #6 was observed on the floor in the shower down, alert and oriented with . Resident #6 was not able to explain the due to , hematoma noticed on his left forehead and approximately 2x4 cm. on left arm. Resident reported a , Emergency Medical Service ( ) was called and he was sent out to the Emergency Room (ER). Progress Note indicated Resident #6 was found on the floor in his room laying on his on the floor in front of his recliner. He stated her and hit his . was called. Resident #6 was transported to the Emergency Room via ambulance. Progress Note indicated Resident #6 was found on the floor in his room alert and oriented with , hematoma noted in his forehead and on his left arm, was called, resident sent to ER for evaluation. Progress Note indicated Resident #6 was found on the floor in the hallway laying on his on the floor. He stated that he had hit his . was called and he was sent to the ER for evaluation. Resident #6's Health Assessment Form 1823 (1823) dated indicated Resident #6 was a risk. Resident #6's service plan indicated he required safety checks every hours. A mobility risk assessment had been completed for	A 025		

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A 025	Continued From page 6 Resident #6 on , but did not indicate whether Resident #6 was a low, medium or high risk for . No Morse Scale was found in Resident #6's chart. On at 10:21 a.m., Staff E (resident aide) said to see if a resident is a risk you can look in the Medication Administration Record (MAR), or point of care app on their phones which told them everything about each resident and said it is also on the white board in the nurses station. She explained with risks some are 1 hour versus 2 hour check, she said the nurses let them know. Staff E said she had worked with Resident #5 and said he has had some . She accessed Resident #5's Plan Of Care (POC) on her phone but was unable to verify if Resident #5 was a risk and said maybe because he was out of the building in the hospital. She said Resident #5 wasn't considered a risk on her shift and said someone considered a risk every day, not every couple of days or weeks. On at 10:30 a.m. Staff F (med tech) said she had also worked with Resident #5 and was also unable to verify his risk status on her phone. She said she agreed that Resident #5 was not considered a risk on their shift and believed someone isn't considered a risk unless they every day. On at 10:45 a.m., Staff H (med tech) said she works both sides A and B of the memory care unit as a med tech. She said she was not familiar with Resident #6. She said you know who was a risk because you can tell by the way they balance, and the nurse will let you know. She identified 2 residents in memory care as risks, one because they use a walker and the other because they use a wheelchair.	A 025		

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A 025	Continued From page 7 . On at 3:16 p.m., Staff I Licensed Practical nurse (LPN) said she works in both Assisted Living and Memory Care. She said Residents are identified as a risk upon assessment and when they first come on unit. She said the care log should state if risk or not. She said the computer should also list risk status. She accessed the computer and was unable to find a completed risk for Residents #1, #5 and #6. After further searching she was able to find a risk assessment for Resident #5 that had been completed in ˬ indicating he was a high risk. On at 9:39 a.m., the Health and Wellness Director (HWD) agreed Residents #1, #5 and #6 had multiple . She said Resident #1 had just moved to memory care and had some psych medications added. The HWD said she liked to pace and you couldn't stop her from pacing. The HWD said Resident #1 didn't really start falling until the move into memory care. She said Resident #6 was new to them and in memory care. The HWD said they had just had a meeting with the family who reported he was having at home up to 3 times a day. The HWD said they tried to get him involved but he liked to go to his room. The HWD said with Resident #5 she thinks it is his medical condition and memory causing the . The HWD said are usually discussed in 24 hour report and then nurses relay information to the staff. On at 11 a.m., the HWD said she would consider anyone with 2 in a week or 2 weeks is a risk and staff are told in report to keep an ˬ on this person. She said it is gone over it in huddle 2 times a day, but there was no documentation of this, it was verbal. She said an	A 025		

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A 025	Continued From page 8 initial assessment and risk assessment are completed when residents move in and when the care plan is updated. The HWD said nothing comes up on a task log that says they are a risk, it has to be communicated verbally. The residents have no identifying arm to alert to risk and nothing in the room identifying them as a risk. She said all resident plans have safety checks, just the frequency may vary by person. The HWD reviewed the mobility risk assessments (risks) for Residents #1, #5 and #6. All said 0 for points. The HWD said she didn't know what caused the points. She said the facility doesn't have actual list of who is risk and staff find out who is risk by word of . On at 11:38 a.m., the Administrator said about months ago the facility switched from filling out the risk assessment on their Point Click Care (PCC) computer system and were now using the mobility assessment on the Vitals system. She explained they used to do risk assessment on PCC which gave a high/med/low risk for (which correlated to the Morse Scale), but the new Vitals system did not indicate a level for risk for . The points on the Vitals system indicated a service level. There are points assigned in the question but it doesn't correlate to the level of risk. The corporate policy for had not been updated to reflect this switch in the computer assessment of . The Administrator said they were able to pull a past PCC risk assessment for Resident #5 completed in which showed a score of 75 which indicated a high risk for . The Administrator said due to the computer system switch, they would not have this for Resident #1 or #6. The Administrator said this change would have caused some with staff.	A 025		

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A 025	Continued From page 9 . Class III	A 025		
A 076 SS=J	59A-36.009 FAC ( ) (1) POLICIES AND PROCEDURES. (a) Each assisted living facility must have written policies and procedures that explain its implementation of state laws and rules relative to ( ). An assisted living facility may not require execution of a as a condition of admission or treatment. The assisted living facility must provide the following to each resident, or resident's representative, at the time of admission: 1. Form SCHS- , "Health Care Advance Directives - The Patient's Right to Decide," , , or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in chapter 765, F.S. Form SCHS- is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308 or the agency's website at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and, 2. DH Form 1896, Florida Form, , 2004, which is hereby incorporated by reference. This form may be obtained by calling the Department of Health's toll free number 1(800)226-1911, extension 2780 or online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04005. (b) There must be documentation in the	A 076		

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A 076	Continued From page 10	A 076		

resident's record indicating whether a DH Form 1896 has been executed. If a DH Form 1896 has been executed, a yellow copy of that document must be made a part of the resident's record. If the assisted living facility does not receive a copy of a resident's executed DH Form 1896, the assisted living facility must document in the resident's record that it has requested a copy.
(c) The executed DH Form 1896 must be readily available to medical staff in the event of an emergency.
(2) LICENSE REVOCATION. An assisted living facility's license is subject to revocation pursuant to section 408.815, F.S., if, as a condition of treatment or admission, the facility requires an individual to execute or waive DH Form 1896.
(3) PROCEDURES. Pursuant to section 429.255, F.S., an assisted living facility must honor a properly executed DH Form 1896 as follows:
(a) In the event a resident experiences or , staff trained in , ( ) or a health care provider present in the facility, may withhold (and).
(b) In the event a resident is receiving hospice services and experiences or , , facility staff must immediately contact hospice staff. The hospice procedures take precedence over those of the assisted living facility.

This Statute or Rule is not met as evidenced by:
Based on record review, and interview, the facility failed to ensure appropriate documentation of a was available in the resident record. The facility also failed to ensure an appropriately trained staff member made the

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A 076	Continued From page 11 decision to perform or withhold , , ( ) efforts for 1 (Resident #2) of 1 resident reviewed for which facility staff performed . The findings included: Facility Policy DP03 - Working with Advanced Directives, policy date . . . . Procedure: 5. If the resident provides the Community with changes to their orders, the most recent copy of the orders must be immediately updated in both the resident's record and in the resident's apartment. . . . 11. In the event of a crisis: a. If the resident is NOT receiving Hospice services, Emergency Medical Services should be immediately summoned for the resident. . . . B. If the resident is receiving Hospice services, and has a order, the hospice nurse may be summoned in lieu of calling 911, in the event the resident has stopped breathing, and the has stopped beating (or other life-threatening emergency) that is directly related to the expected course of the resident's illness. Facility Policy GP12 - Staffing, Emergency Training, , , , ( ) and First Aid Training, policy date . . . ,Policy: The Executive Director is responsible to ensure properly trained Community staff are available to respond to emergencies at all times and provide necessary care/supervision of residents. . . . Procedure: 7. Discovery Management Group staff will promptly respond to all emergencies within the community. A. If a resident is experiencing a serious or life-threatening emergency, 911 will be immediately called. . . . 8. If the resident is experiencing , , to , Emergency Medical Services (911) will be called	A 076		

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A 076	Continued From page 12 immediately and: a. If the resident does not have a valid " ( ), an appropriately trained Community staff member will initiate , unless it is obvious from physical observation of the resident's body (e.g., body is stiff, cool to the touch, blue or grayish color, etc.) that such efforts would be futile and there is not a physician, authorized registered nurse, or physician assistant onsite to assess and provide other direction. A review of section 8 above suggests unlicensed unqualified caregivers would assess the resident's condition and determine if would be viable for the resident and choose to provide or not, reguardless of the Resident's Advanced Directives. Review of the facility Admission and Discharge log indicated Resident #2 expired on . Record review of Resident #2's chart revealed she had been hospitalized on - and returned to the facility on . A Health Assessment Form 1823 dated indicated Resident #2 was under Hospice Care. Resident #2's chart did not contain documentation of an order for a or an executed DH Form 1896, Florida Form. Further review of Resident #2 chart revealed Three (3) Progress notes were entered for which read: "6:06 a.m. Resident was found unresponsive with no , and no , POA made aware. 6:27 a.m. Hospice was called at 6:27 a.m. This writer informed them that resident has , . Hospice said they will send someone out as soon as possible. 13:45 Funeral home came in to remove resident body."	A 076		

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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 076	Continued From page 13 On at 11:20 a.m., during an interview, the Health and Wellness Director (HWD) said Resident #2's code status had been up in the air. She said Resident #2 had entered Hospice services while in the hospital, but the facility had no Hospice documentation in-house (consent, care plan, order). The HWD confirmed there was no documentation in Resident #2's chart that had been initiated, that Emergency Medical Services had been called or arrived at the facility. The HWD said Licensed Practical Nurse (LPN) Staff A had called her, to let her know Resident #2 wasn't breathing and she told Staff A to start after asking if there was a . The HWD said she was unaware if anyone else was with Staff A. The HWD said she wasn't sure if anyone else was in the building that was certified. The HWD said for night shift, only 1 person is staffed that is qualified for the whole building and Staff A had been the nurse for the entire building. On at 11:44 a.m., during an interview, LPN Staff A said she only works 1 night a week and didn't know the whole scenario with Resident #2. Staff A said she had no paperwork when the Memory Care Aide called. Staff A said she went to the Memory Care, and found Resident #2 unresponsive, she started , but she had worked for Hospice 16 years, and knew Resident #2 was . Staff A said she stopped and then called the HWD and then went to the office to look for the paperwork. Staff A said arrived and she told them Resident #2 was in the room unresponsive. Staff A said she was by herself and had to go to check Resident #2's chart to get information. Staff A said when arrived no one was doing on Resident #2. Staff A said when she went to Resident #2's chart	A 076		

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	AL11969236	A. BUILDING: _____ B. WING _____	01/22/2025

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A 076	Continued From page 14	A 076		

she did not find paperwork in her chart. Staff A said she did not know if anyone else in building was certified.

On at 12:00 p.m., during an interview, the HWD said she did not have a copy of Staff A's certification in the facility. She said Staff A had texted her a picture. On review of the photo, it was determined Staff A's certification did not meet requirements as it was completed online with no on, skills demonstration. The HWD said she could not explain why she had no documentation on to show whether Staff A had current valid certification.

On 2:45 p.m., during an interview, the Administrator said she was told about Resident #2 in the morning when she came in. The Administrator said she did not know know which staff actually found Resident #2 unresponsive without talking to the staff. The Administrator said no investigation had been done. Administrator said typically, if or when a resident goes on Hospice, the admitting hospice nurse gives them the documentation. The Administrator said it was a miss.

On at 2:50 p.m., during an interview, the HWD said when Resident #2 returned to the facility, the Hospice nurse had come to the facility. The HWD said she guessed the Hospice nurse just assumed all the paperwork was in the chart because Resident #2 came from the hospital, but it was not. The HWD said normally the family gives us the advanced directive when a resident moves in, and as they obtain them from doctors; the nurse is responsible for filing them in the chart and making sure there is a copy at the front desk. The HWD said shame on herself because she just assumed the was in the

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A 076	Continued From page 15 record for Resident#2, because Hospice always does it. The HWD said if it had been in the chart, it would have saved a lot of problems. On at 3:12 p.m., during an interview, Resident Aide Staff B said she was the one who discovered Resident #2 unresponsive. Staff B said they do rounds every hour, and she and the nurse were with Resident #2 at 1:45-2 a.m. to change her position. Staff B said she checked her again around 3 a.m. and she was ok, and at 4 a.m. she changed her position again. Staff B said she then went to take care of another resident, and had to go in the hall to get something and when she passed Resident #2's room she noticed something different and found Resident #2 wasn't breathing. Staff B said she called the nurse right away, around 4:10 a.m. Staff B said Staff A started in front of her, but she doesn't know how long she did because another resident was screaming and she went to take care of them. Staff B said when came in, nobody was doing on Resident #2. On at 3:30 p.m., during an interview, Resident Aide Staff D said if she finds a resident unresponsive, she would call a supervisor or call a co-worker. On 3:25 p.m., during an interview, Resident Aide Staff E said if she found a resident unresponsive she would call the nurse to check on the patient, if the nurse was not there, she would call a supervisor or manager. If they are not available, she would call the nurse in Assisted Living. On at 1:33 p.m., during an interview, the HWD said the process when a resident is found unresponsive should be: Staff should call for help,	A 076		

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A 076	Continued From page 16 have someone check the , if no grab the Automated External Defibrillator ( ) and start or have someone grab it on the way in to help you. If we have someone available we should have 2 people. This is gone over in training. On 3:16 p.m., during an interview, LPN Staff I said if she came across an unresponsive resident, first she would see if they have a , , if no , , she would start and ask aide to go see if they have . Staff A said if they have a then she would stop . If they don't have a , she would continue , either her or the aide. She said then one of them would call 911 and get the proper paperwork for the ambulance. On at 3:00 p.m., during an interview, LPN Staff A said the Memory Care aide called for her maybe around 4 a.m. Staff A said she had been on the other side of the building and it took about minutes to get to memory care. She said she started for about 25 minutes and stopped, no one was in the room to assist her. Staff A said she was trained to check , and start because she didn't know if the resident was a or not, if no , & not responsive then start . Staff A said was probably called around 4:30 p.m. but she doesn't remember the time. Staff A said there was no hospice paperwork and no interdisciplinary care plan documentation in the chart for Resident #2. Class 1 .	A 076		

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A 083	Continued From page 17	A 083		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure that staff members possess Current valid , , ( ) certification that requires the student to demonstrate, in person, that he or she is able to perform and issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization who is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education for 1 (Staff A) of 1 staff who performed on a resident.	A 083		

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A 083	Continued From page 18 The findings included: Review of the facility Admission and Discharge log indicated Resident #2 expired on . On at 11:44 a.m., during an interview, Staff A (LPN) said she was called to the memory care (MC) unit and found Resident #2 to be unresponsive. Staff A said she began on resident #2, but determined Resident #2 was and stopped to call the Health & Wellness Director and check Resident #2's chart to see her /code status. Staff A said when the Emergency Medical Services ( ) arrived, no one was performing on Resident #2. On at 12:00 p.m., the HWD said she did not have a copy of Staff A's certification in the facility. She said Staff A had texted her a picture. On review of the photo, it was determined Staff A's certification did not meet requirements as it was completed using an online class, with no on, skills demonstration. The HWD said she could not explain why she had no documentation on to show whether Staff A was currrent with valid certification. . Class III	A 083		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows:	A 162		

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A 162	Continued From page 19 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that not be taken.	A 162		

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A 162	Continued From page 20 (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy,	A 162		

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A 162	Continued From page 21 guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure resident record contained required documentation of a Hospice interdisciplinary care plan and ( ) for 1 (Resident #2) of 1 resident for whom staff started then discontinued performing . , ( ) efforts.	A 162		

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A 162	Continued From page 22 The findings included: Facility Policy DP03 - Working with Advanced Directives. Policy date . Policy: Discovery managment group staff will honor all resident Advance Directives. . . Procedure: 5. If the resident provides the Community with changes to their orders, the most recent copy of the orders must be immediately updated in both the resident's record and in the resident's apartment. . . .9. The status list will be updated and replaced in all designated locations anytime a resdient has a change in status. Review of the facility Admission and Discharge log indicated Resident #2 expired on . Record review of Resident #2's chart revealed she had been hospitalized on - and returned to the facility on . A Health Assessment Form 1823 dated . . . indicated Resident #2 was under Hospice Care. Resident #2's Chart did not contain evidence of an order for or an executed DH Form 1896, Florida Form. On at 11:44 a.m., in a telephone interview with Staff A(LPN) said she only works 1 night a week, and didn't know the whole scenario with Resident #2. Staff A said she had no paperwork for Resdient #2 when the Memory Care Aide called. Staff A said she went to the Memory Care unit, and found Resident #2 unresponsive. Staff A said she started , but she had worked for Hospice for 16 years, and knew she was . Staff A said she stopped and then called the HWD and then went to the office to look for the paperwork. Staff A said arrived and she told them Resident #2 was in the room unresponsive. Staff A said she was by herself	A 162		

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A 162	Continued From page 23 and had to go check the chart to get information. Staff A said when arrived no one was doing on Resident #2. Staff A said when she went to Resident #2's chart she did not find paperwork in her chart. Staff A said she did not know if anyone else in building had been certified. On at 2:50 p.m., the HWD said when Resident #2 returned to the facility, the Hospice nurse had come to the facility. The HWD said she guessed the Hospice nurse just assumed all the paperwork was in the chart because Resident #2 came from the hospital, but it was not. The HWD said normally family gives advanced directives when a resident moves in, and if they obtain them from doctors, the nurse is responsible for filing them in the resident chart and making sure there is a copy at the front desk. The HWD said shame on herself because she just assumed the was in the record for Resident#2, because Hospice always does it. The HWD said if it had been in the chart, it would have saved a lot of problems. On at 3:00 p.m., during an interview, Staff A said the Memory Care aide called for her maybe around 4 a.m. Staff A said she had been on the other side of the building and it took about minutes to get to the memory care unit. She said she started for about 25 minutes and no one was in the room to assist her. Staff A said she was trained to check for a , and start . and she didn't know if there was a or not, if no , & not responsive start . Staff A said there was no hospice paperwork and no interdisciplinary care plan documentation in the chart. .	A 162		

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A 162	Continued From page 24 Class III	A 162		
A 165 SS=D	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.	A 165		

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A 165	Continued From page 25 (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse 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	A 165		

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A 165	Continued From page 26 through any investigation, has reasonable belief that conduct by a staff member or employee of a 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 record review, and interview, the facility failed to submit within 1 business day after the occurrence of an adverse incident a preliminary report to the agency for an adverse incident resulting in for 1 (Resident #2) of 1 resident reviewed. The findings included: Review of the facility Admission and Discharge log indicated Resident #2 expired on . Record review of Resident #2's chart revealed she had been hospitalized on - and returned to the facility on . A Health Assessment Form 1823 dated indicated Resident #2 was under Hospice Care. Resident #2 Chart did not reveal an order for or an executed DH Form 1896, Florida Form. On at 11:20 a.m., the Health and Wellness Director (HWD) said Resident #2's	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969236	A. BUILDING: _____ B. WING _____	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 165	Continued From page 27 code status had been up in the air. She said Resident #2 had entered Hospice services while in the hospital, but the facility had no Hospice documentation in house (consent, care plan,), so they started . The HWD confirmed there was no documentation in Resident #2's chart that had been initiated, that Emergency Medical Services had been called or arrived at the facility. The HWD said according to what she had been told, they found Resident #2 unresponsive and she had been checked 2 hours prior. HWD said Staff A told her she had started , she was unaware if anyone else was with Staff A. The HWD said 911 was called and that Staff A had called her, to let her know Resident #2 wasn't breathing and she told Staff A to start after she asked if there was a . The HWD said she wasn't sure if anyone else had been in the building that was certified and said for night shift, only 1 person is staffed that is certified for the whole building and Staff A had been the nurse for the entire building. On at 11:44 a.m., in a telephone call with Staff A, she said the memory care Aide called and said Resident #2 was unresponsive. Staff A said she went to the memory care unit and started . Staff A said she had worked for Hospice 16 years, and knew she was . Staff A said she stopped and then called the HWD and then went to the office to look for the paperwork. Staff A said arrived and she told them Resident #2 was in the room unresponsive. Staff A said she was by herself and had to go check the chart to get information. Staff A said when arrived no one was doing . Staff A said when she went to Resident #2's chart she did not find paperwork in her chart. Staff A said she did not know if anyone else in building had been	A 165		

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A 165	Continued From page 28 certified. On at 12:00 p.m., during an interview, the HWD said she did not have a copy of Staff A's certification in the facility. She said Staff A had texted her a picture. On review of the photo, it was determined Staff A's certification did not meet requirements as it was an online class with no on, skills demonstration. The HWD said she could not explain why she had no documentation on to show whether Staff A was current with valid certification. On 2:45 p.m., the Administrator said she was told about Resident #2 in the morning when she came in. The Administrator said she did not know which staff actually found Resident #2 unresponsive without talking to the staff. The Administrator said no investigation had been done. On at 2:50 p.m., the HWD said when Resident #2 returned to the facility, the Hospice nurse had come to the facility. The HWD said she guessed the Hospice nurse just assumed all the paperwork was in the chart because Resident #2 came from the hospital, but it was not. The HWD said normally family gives advanced directive when a resident moves in. If they obtain them from doctors, the nurse is responsible for filing them in the chart and making sure there is a copy at the front desk. The HWD said shame on herself because she just assumed the was in the record, because Hospice always does it. The HWD said if it had been in the chart, it would have saved a lot of problems. On at 9:39 a.m., the HWD said no adverse incident report had been done on Resident #2 as she didn't know Staff A stopped	A 165		

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A 165	Continued From page 29 and agreed documentation was lacking. The HWD said she didn't know Staff A wasn't properly certified because they hadn't had her card on file, it had slipped through the cracks. On at 1:33 p.m., the HWD said the process when a resident is found unresponsive should be: Staff should call for help, have someone check the , if no grab the Automated External Defibrillator ( ) and start or have someone grab it on the way in to help you. If we have someone available we should have 2 people. This is gone over in training. . Class III	A 165		