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
	AL11968966	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTRY PARK ORLANDO	3201 CENTER POINT DR ORLANDO, FL 32825

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A 000	Initial Comments A complaint investigation (2025000329) and a generator monitoring were conducted at Gentry Park Orlando on . The facility had a deficiency at the time of the survey.	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 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	A 025		

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A 025	Continued From page 1 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 provide care and services appropriate to meet the safety needs for 1 of 1 sampled resident who experienced a of unknown origin (5.) Findings: Review of resident #5's record revealed a facility admission date of . A health assessment form (1823) indicated the resident's medical history included , , and , , special precautions were risk, , and aphasia and supervision with ambulation, bathing, and , and independent with grooming, toileting and	A 025		

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A 025	Continued From page 2 transferring. A facility risk assessment indicated the resident was not a risk. A assessment indicated the resident was a risk. On at 11:19 am nurse F documented that on at approximately 7:30 am a caregiver noticed the resident was still in bed, so the caregiver let the resident sleep. Breakfast arrived at 9 am and when the caregiver went to get the resident the caregiver noticed the resident was not herself. The resident had a long-sleeved shirt on, and the caregiver helped the resident put her pull up on and her pants. When the caregiver and resident were walking to the dining room the resident pointed to her right arm. The resident was nonverbal and usually pointed to bring attention to something. The caregiver did not understand at that moment what the resident was trying to say. The resident sat down in the dining room and did not finish breakfast, which was unusual for her. A different caregiver called the wellness director, who instructed the caregiver to call emergency medical services (.) When the resident's family member was notified, they asked that be cancelled, and they would take the resident to an emergency room themselves. The caregivers went to check on the resident and found that she . The caregivers took the resident to her room to change her and that is when they noticed a large on her right arm. The family member arrived and took the resident to a hospital. The director of nursing (DON) documented a late entry regarding the incident, which indicated the family member called the facility just before 3 pm on and said the resident's right was	A 025		

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A 025	Continued From page 3 There was no documentation to indicate the resident had any or other incidents prior to . On at 10:36 am, caregiver A said she did not remember if she saw a on the resident's arm. She did not remember anything happening. She said if so, she would have notified someone. On at 10:50 am, caregiver B said that when she arrived at work on at 7 am the resident was fully clothed, wearing a long-sleeved shirt and sitting on the toilet in her bathroom. The caregiver said the resident used her walker to go to the dining room for breakfast. She said the resident usually ate all her food but this time she didn't. Due to this, the caregiver called the nurse. The caregiver assisted the resident to stand and return to her room, at which time the resident moaned and grimaced. Once in the room the caregiver changed the resident's shirt and saw a purple and on the resident's right upper arm. On at 11 am, caregiver C said she assisted caregiver B with changing the resident's shirt and she too saw the . She said she called the DON, who said send the resident to a hospital. The resident's family member came and took the resident instead. The caregiver said the resident normally walked independently with a steady gait. She said the resident forgot to use her walker at times. On at 11:10 am, caregiver D said the resident did not eat her breakfast that morning and when assisted up, she moaned and grimaced.	A 025		

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A 025	Continued From page 4 On at 12 pm, the DON said the facility did not have a policy regarding injuries of unknown origin. On at 12:25 pm, caregiver E said that on between 5:30 am and 5:45 am she saw the resident sitting on the toilet and briefs were all over the floor. She said it was not unusual for the resident to get up and down during the night and that each time she used the bathroom she changed her own brief. She said on that morning the resident was holding her like she had to use the bathroom. She asked the resident if her hurt, and the resident shook her "no." She said she dressed the resident in sweatpants and a floral short-sleeved shirt, and she did not see a on the resident's arm. She said the resident did not point to her arm or act like she had . She said there were no incidents that night, such as the resident falling. She said sometimes the resident veered when she walked and sometimes did not use the walker while walking in her room. She said a couple of days afterwards she noticed the bathroom door, which normally slid smoothly open and closed, was jammed which led her to believe something may have occurred involving the door. She said the DON called her the same day as the incident and asked her questions about the injury. On at 1 pm, nurse F said she was not working the day of the incident. She said the DON called her to inform her of the . She said she questioned 3 pm-11 pm staff who worked on and was told there was no at that time. She said the resident had a history of . She said the resident walked independently using a walker and only needed an	A 025		

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A 025	Continued From page 5 escort or redirection at times. Class III	A 025		