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
	AL11964204	A. BUILDING: _____ B. WING _____	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD PLACE	2680 CROTON ROAD MELBOURNE, FL 32935

(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 A re-licensure survey and a generator monitoring were conducted on at Greenwood Place Assisted Living Facility. There were deficiencies identified at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of 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 observation, record reviews, and interviews the facility failed to provide adequate supervision and provide care and services appropriate to meet the needs of residents by failing to ensure safety through proactive measures to minimize the potential for and injuries and injury of unknown injury for 1 of 3 residents sampled (#11) and 2) The facility failed to provide care and services appropriate to meet the needs of residents by failing to monitor the general health, safety, and physical wellbeing of residents when the temperature exceeded 81 degree °F in the activity room, lobby, and dining room.	A 025		

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A 025	Continued From page 2 Findings: On documented at 2:26pm - resident #11's third party nurse visited and noticed a change in her condition. The third-party nurse called 911. Resident #11 was transferred to the hospital where she was diagnosed with a right . A review of resident #11 record revealed she was admitted on . Her record contained a resident health assessment form (1823) dated . Her diagnoses included , , , and overactive . She required assistance with ambulation, transfer, and toileting. On documented at 5:29pm - Resident post . The resident complained of , and discomfort. Given prescribed , medication. Resident encouraged to use call bell. On documented at 10:35am - Observed resident #11 on the floor. Small hematoma to the of her . Resident alert with . Resident stated she was walking around her room and lost her balance and . Resident stated she hit her and she did not want to go to the hospital. Transferred to the hospital and diagnosed with multiple to and left , . On at 5:55pm the resident was and was unsteady when walking. On at 5:32pm Resident had some due to and recent hospitalization. Went to check on her and she was found supine on the floor sleeping in a red blanket. She said she decided to sleep on the floor because she couldn't find her bed. On at 5:43pm resident observed on the	A 025		

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A 025	Continued From page 3 bathroom floor in her room. Said she trying to get in the shower and hit her on the floor. The resident requested to go to the hospital. On documented at 5:22pm. The resident found on the floor next to her bathroom door. No injury. Awake, alert, and oriented. Resident said she was trying to go to the bathroom, lost her balance, and . A review of resident #11's Service Plan found and mitigating strategies were last updated in and included check frequently (no timeframe documented), offer reassurance, invite, encourage and assist to activities. Provide similar one-on-one activities if unable to attend group activities. Rearrange room to remove any clutter. Remind to use call device. referral for strength and mobility/balance. A review of the facility policy titled Management Program dated revealed a was defined as an unintended landing on a floor or lower position. mitigating strategies were defined as activities to lessen, diminish, or minimize the chances of a potential from occurring. On at 3:10pm interview with the Director of Nursing (DON). She confirmed resident #11 had multiple unwitnessed . She did have home health for strengthening. She was compliant with care. The last known was on . Resident #11 went to the hospital after refusing. She returned in less than 24 hours without any diagnosis of injury. When she went to the hospital on , she was diagnosed with a . She did not believe the resident could get herself off the floor. She confirmed she did not know when or how the right happened.	A 025		

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A 025	Continued From page 4 2. On at 1:47pm an interview with the administrator was conducted regarding the warm temperature in the facility. She said the air conditioning (a/c) in the common areas had not been working since last week, but it is being fixed today. Last week it was very cool and the temperatures in the building were never above 80. The resident rooms are cooled with independent units. On at 2:15pm 18 residents were observed in the second-floor activity room for movie and ice cream social. This surveyor took the temperature with an AHCA provided thermometer and it was 86.2 degrees. The door to the outside was open and the shades were pulled over the windows. The Activity director started to move residents to the first-floor lobby. At 2:20pm facility staff continue to move residents downstairs. The second-floor temperature was 87 degrees. Water was being offered to the residents. The lobby was 82 degrees taken with the AHCA provided thermometer. The outside temperature was 83 degrees F. All residents were then asked to go to their rooms which had functioning air conditioner units. On at 4:20pm an interview with the Maintenance Director was conducted. He said he had been taking the temperatures twice a day since the a/c went out about a week and a half ago. In the morning and in the afternoon. He did not specify the exact times. He called the A/C repair company the same day it went out. He was using an infrared thermometer which he said was there when he started working. He had not calibrated it and did not know if it could be	A 025		

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A 025	Continued From page 5 calibrated. He said he bought 2 portable units today ( ) and borrowed 2 from their sister community. The administrator provided temperature logs for - (20 days). The logs had documentation of AM and PM temperatures for A, B, C, D halls, dining room, activity room, and lobby. There were no times documented with the temperatures. A/C repair invoices provided. They had the following documentation: A quote to replace core sense module was sent in of 2024. A new quote to replace core sense module . Strongly suggest replacing the module and purchasing an additional one for up. There are limited modules in the state. found heat exchanger had cracked and let water in the refrigeration circuit. Did not install any parts. Greenwood management to determine what they would like to do. No repairs were made. . Compressor to be replaced days to receive part from date of approval. 3 other compressors are in similar condition. The base of the unit is in poor condition. Suggest replacement of the chiller due to overall condition. Greenwood management to determine what they want to do. I highly suggest new equipment. Chiller is not cooling at all. Also, there was no heat for the building at that time. Recommend replacing unit. Review of the facility emergency plan for HVAC failure: "The purpose of this plan is to care for residents during a failure of air conditioning, heating, or systems and prevent hyperpyrexia and (1) Upon failure of the air conditioning or heating,	A 025		

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A 025	Continued From page 6 thermometers shall be monitored at four-hour intervals during daylight hours. (2) The executive director (ED) and the county health unit shall be notified within one hour of the onset of air conditioning failure. (3) When the temperature of any resident area exceeds 82 degrees F the facility staff should be alerted to potential danger. (4) When the temperature of any resident area reaches 82 degrees F, for a period of four hours duration, the ED and the county health unit shall be notified. (5) When the facility temperatures reach 82 degrees F and remains so for four consecutive hours, facility staff should open doors and windows, activate fans ensure an adequate supply of ice, force fluids to residents, monitor resident temperatures and relocate residents at high risk. On at 3:30pm in an interview with the administrator, she confirmed they were checking the temperature only twice a day and no times were documented on the temperature logs. Per the facility policy number 1. Upon failure of the air conditioning or heating, thermometers shall be monitored at four-hour intervals during daylight hours. She confirmed she did not notify the county Heath Unit. Per facility policy number 2. The executive director (ED) and the county health unit shall be notified within one hour of the onset of the air conditioning failure. (Photo Evidence Obtained) Class II	A 025		