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 _____	R 02/03/2025

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

(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 revisit survey was conducted on at Discovery Commons Cypress Point, an assisted living facility in Fort Myers, Florida. This was the follow up to the complaint survey for # 2025000124 & 2025000668 conducted on through . Based on the plan of correction and documentation provided the citation A 0076 at class I level, was corrected. 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	{A 025}		

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{A 025}	Continued From page 1	{A 025}		

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 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.

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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, 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 dated . . . . . 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 ˬ and agitated behaviors.
The progress note on indicated Resident #1 was found on the floor around 7:45 p.m., with no apparent injuries.

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{A 025}	Continued From page 3 The progress note on indicated at 1:10 a.m., Resident #1 was on the floor in her room with no apparent injury. The 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 Resident #1 was transported to the hospital. The progress note dated indicated staff had spoken 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 . A 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.	{A 025}		

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{A 025}	Continued From page 4 The 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 . The 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 . The 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. The 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. The 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.	{A 025}		

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{A 025}	Continued From page 5 3. On a review of the facility incident log revealed Resident #6 had 8 in the previous 30 days, on , , , , , , and . The review of Resident #6's chart revealed he was a memory care resident, and progress notes indicated the following: The 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. The progress note dated indicated Resident #6 was heard calling for help and found sitting on the floor in the bathroom. Resident #6 said he and asked to help get him up. Resident #6 had a to his left arm. The progress note dated indicated Resident #6 was found in a sitting position on the floor in the bathroom. He was helped off the floor and a small was noted on his left . The progress note dated 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. The progress note dated 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 he had a measuring approximately 2x4 centimeters. (cm). on the left arm. Resident #6 reported a . Emergency Medical Service ( ) was called and he was sent out to the Emergency Room	{A 025}		

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{A 025}	Continued From page 6 (ER). The progress note dated indicated Resident #6 was found on the floor in his room laying on his , on the floor, in front of his recliner. He stated he and hit his . was called. Resident #6 was transported to the Emergency Room via ambulance. The progress note dated indicated Resident #6 was found on the floor in his room alert and oriented with . A hematoma was noted on his forehead and a he had a on his left arm. was called, and Resident #6 was sent to ER for evaluation. The progress note dated 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 Resident #6 on , but did not indicate whether Resident #6 was a low, medium or high risk for . There was 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 a 2 hour check. She said the nurses let	{A 025}		

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{A 025}	Continued From page 7	{A 025}		

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 medication technician. 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.

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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

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{A 025}	Continued From page 8 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 , , 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 the 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 11:00 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 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 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	{A 025}		

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{A 025}	Continued From page 9 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 [brand name] computer system and were now using the mobility assessment on the [brand name] system. She explained they used to do risk assessment on the computer program which gave a high/med/low risk for (which correlated to the Morse Scale), but the new [brand] system did not indicate a level for risk for . The points on the new [brand] 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 [brand] 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. . Class III	{A 025}		
{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	{A 083}		

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{A 083}	Continued From page 10 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 a current valid ( ) certification that requires the student to demonstrate, in person, that he or she is able to perform and was 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. 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,	{A 083}		

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{A 083}	Continued From page 11 Staff A Licensed Practical Nurse (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: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number,	{A 162}		

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{A 162}	Continued From page 12 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. (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.	{A 162}		

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{A 162}	Continued From page 13	{A 162}		

(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, 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.

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 _____	R 02/03/2025

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

(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 162}	Continued From page 14 (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 each 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. The findings included: Facility Policy DP03 - Working with Advanced Directives. Policy date . Policy: Discovery management group staff will honor all resident Advance Directives. . . Procedure: 5. If the	{A 162}		

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 _____	R 02/03/2025

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{A 162}	Continued From page 15 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 resident 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 Resident #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 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	{A 162}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 162}	Continued From page 16 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 4:00 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 . She said 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. . Class III	{A 162}		
{A 165} SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality	{A 165}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 165}	Continued From page 17	{A 165}		

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 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

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{A 165}	Continued From page 18	{A 165}		

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 licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.

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DISCOVERY COMMONS CYPRESS POINT	6870 ALISTER WAY FORT MYERS, FL 33912

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{A 165}	Continued From page 19 (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's 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 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	{A 165}		

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{A 165}	Continued From page 20	{A 165}		

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. The 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 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

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{A 165}	Continued From page 21	{A 165}		

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 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.

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{A 165}	Continued From page 22 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}		