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
	AL11969621	A. BUILDING: _____ B. WING _____	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT LIBERTY PARK	1321 NE 24TH AVENUE CAPE CORAL, FL 33909

(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 complaint investigation for #2026006850 was conducted at Atrium at Liberty Park on . Deficiencies were identified 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	A 025		

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A 025	Continued From page 1 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 provide supervision to maintian a general awareness of the residents whereabouts for 1 (Resident #3) of 11 residents reviewed. 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: (b) Daily observation by designated staff of the activities of the resident while on the premises, and	A 025		

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A 025	Continued From page 2 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 findings included: Record review revealed Resident #3 was admitted to the facility on . Further review revealed a Resident Health Assessment (HA) Form which included the following diagnosis: insufficiency dated . Resident #3 was Independent with activities of daily living (ADLs). Resident #3 did not need assistance with medications. Record review showed there was a on record ( ) that was completed on . Record review of the Service plan Report for Resident #3 dated indicated Resident #3 was independent with toileting, . Resident #3 self-administered medications to herself. Resident #3 was able to evacuate independently during an emergency. Per Service plan Report dated ; Resident care assistant (RCA) to make the bed daily and remove trash daily every shift. Record review of facility progress notes for Resident #3 indicated on : at approximately 5:04 p.m. Resident #3's son arrived at the community and proceeded to to visit his mother. Shortly after arrival, son alerted staff that his mother was on the floor and alerted the care partner. Per documentation on record Resident #3 was unresponsive. Emergency Medical Services ( ) was called.	A 025		

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A 025	Continued From page 3 Resident #3 status was verified. No was initiated in accordance with the resident's order. Law enforcement was called and contacted the medical examiners office. No autopsy was required. During an interview the facility's Health and Wellness Director (HWD) on at 10:10 a.m., said Resident #3 had a . Resident #3 was independent with activities of daily living (ADLS) and did not require assistance with medications. Resident #3 was found by her son, laying on the floor by the door. Resident #3 was unresponsive. 911 was called. notified the medical examiner (ME) and he refused to perform an autopsy. The HWD said she established the last observation had of Resident #3 was during dinner the night before ( ) around 7:00 p.m. Resident #3 was found by her son the next day ( ) around 5:00 p.m. The HWD said she was aware of the fact that Resident #3 had a service plan indicating inclusion of the service of making the bed daily and picking up the trash 3 times a day. The HWD said Resident #3 was very independent and did not want anyone to make her bed. She was making her own bed. The HWD said Resident #3 had a tendency to leave the trash outside the door for the caregivers to pick up. HWD said Resident #3 did not eat breakfast most of the mornings, but usually would go to the dining room for lunch and dinner. The HWD said they included the task on Resident #3's plan of care and all staff were expected to check residents and documents on the log regardless of if they were independent or not. There was no documentation on Resident #3's record indicating Resident #3 liked to make her own bed, throw away trash or skip breakfast.	A 025		

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A 025	Continued From page 4 Interview with Resident #3's son on at 12:33 p.m.. He said he tried calling his mother a couple of times that day, the last time he saw her was days before the event. and he initially did not think of anything of her not answering the phone, but by the end of the day it was close to 5 p.m. so, he went to the facility and found his mother on the floor by the door. Resident #3's son said she was purple. He called 911 and the staff came in. 911 personnel on the phone instructed him to find an (Automated External Defibrillator) but she was already gone. He said he believed had set in. He did not know if his mother was making her own bed or not , but he assumed she did since she was able to do so. He said he did not know if his morn had a tendency of leaving the trash out the door for the staff to pick up or not. He said he was very upset because she did not show up for her meals, breakfast and or lunch and no one bothered to go and check on her. She tended to sleep in about 8:30 to 9 a.m. then sometimes went to breakfast, then lunch, then activities with her friends she was very active and alert. Resident #3's son said staff told him the caregivers were supposed to check on the residents in the beginning and end of the shift, but he did not remember who and he did not have it in writing. Resident #3's son said " they said she was unresponsive, but she was ." Staff A said during an interview on 1:22 p.m. she was working in the morning ( )and did not check on Resident #3. Staff A said It was not routine for her to check on Resident #3. Staff A said Resident #3 did not go out for breakfast, only lunch and dinner. During an interview, Staff B Medication technician said on at 1: 30 p.m. she was	A 025		

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A 025	Continued From page 5 working on the day ( ) but she did not see Resident #3. Staff B said since resident #3 took her own medications she did not have a reason to go to her room. Staff B stated, "she would leave the trash outside herself, so we did not have a reason to go the room." During an interview, Staff C medication technician said on at 2:04 p.m., she did not see Resident #3, and she did not have to go to check on her since she did not assist with self-administration of medications. Staff D said during an interview on 2:09 p.m. she was working the morning of the incident ( ) and did not check on Resident #3. Staff D said it was not routine for her to check on Resident #3. Staff D said Resident #3 did not go out for breakfast. only lunch and dinner. Class III	A 025		