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
	AL11965658	A. BUILDING: _____ B. WING _____	02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM COTTAGES OF ROCKLEDGE	3821 SUNNYSIDE COURT ROCKLEDGE, FL 32955

(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 2019017932 and an Extended Congregate Care (ECC) monitoring visit was conducted at Palm Cottages of Rockledge on [redacted]. A deficiency was 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 must notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 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	A 025		

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A 025	Continued From page 1 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 reviews and interviews, the facility failed to adequately supervise 1 of 5 sampled residents (#1) who experienced a [illegible]. Findings: Resident #1's record revealed a facility admission date of [illegible]. A current 1823 health assessment form, dated [illegible], indicated that she has a diagnoses of [illegible], [illegible] and [illegible]. A facility note, dated [illegible] at 6 a.m., indicated that she was found on the floor on a pillow. After lifting her to her [illegible], her ambulation was inspected. She reported "I have a little [illegible]." A health care provider was notified and 911 was called. When emergency personnel arrived, she denied having [illegible], so she was not taken to the hospital. Her [illegible] was [illegible] and her [illegible].	A 025		

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A 025	Continued From page 2 Review of a facility adverse report following the incident revealed the resident said she had been on the floor all night asking for assistance and no one came to her aid. Following a facility investigation, caregiver F's employment was terminated. The facility consists of eight separate resident cottages. Review of staff time sheets for the 11 p.m. to 7 a.m. shift on revealed that eight caregivers and one nurse worked. At 10:15 a.m. on ... . the director of nursing said there was one caregiver assigned to each cottage and if they needed to leave the cottage or take a break, the nurse would be responsible for staying in the cottage. At 11:58 a.m. nurse E, who was the nurse working that night, said she was heading to one of the cottages when she saw caregiver F leave resident #1's cottage to take a break and sit on a curb to smoke. She was unable to remember the time. She said she always passed medications in resident #1's cottage last so when she arrived there at 6 a.m. resident #1 was on the floor. She said the resident looked like she had been on the floor for a long time because her was puffy and red. She said the procedure for staff breaks at night is if there is not a float caregiver working then the caregivers are not supposed to leave their cottage for breaks. She said when she saw caregiver F outside, she did not investigate further or go to resident #1's cottage to provide resident supervision. At 2:22 p.m. the director of nursing said there are surveillance cameras located in resident #1's cottage in the common area, dining room, facing the south door which is near the resident's room	A 025		

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A 025	Continued From page 3 and the patio. She and the administrator said the video footage for the entire 11 p.m. to 7 a.m. shift on … … … was watched and caregiver F was terminated because she was seen on video leaving the cottage at 11:31 p.m. and returning at 12:13 a.m., leaving again at 3:42 a.m. and returning at 4:12 a.m. and she was not seen going into resident #1's room at all during the shift. Class III	A 025		