

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11963791</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/07/2020</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**WEINBERG VILLAGE LLC**

**13005 COMMUNITY CAMPUS DR.  
TAMPA, FL 33625**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 000                    | Initial Comments<br><br>A complaint survey (complaint #2020012890) was conducted on 08/07/2020 at Weinberg Village Assisted Living Facility. Deficient practice was identified during the survey                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | A 000               |                                                                                                                          |                          |
| A 025<br>SS=D            | 429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision<br><br>429.26<br>(7) The facility must 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 shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.<br><br>59A-36.007<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:<br>(a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C.<br>(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.<br>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. | A 025               |                                                                                                                          |                          |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11963791</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/07/2020</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**WEINBERG VILLAGE LLC**

**13005 COMMUNITY CAMPUS DR.  
TAMPA, FL 33625**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 025                    | <p>Continued From page 1</p> <p>(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.</p> <p>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.</p> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the Facility failed to provide care and services appropriate to meet the needs of residents admitted into the Facility for two Residents (#1 and #2) of two sampled residents that were at risk for . . . and required . . . precautions. Furthermore, the Facility failed to follow their . . . Policy and Procedures.</p> <p>Findings included:</p> <p>During an observation of Resident #2, conducted on . . . at 10:00am, Staff A was pushing Resident #2 in a wheelchair. Resident #2 did not have footrests on the wheelchair. Resident #2's . . . kept dragging the carpeted floor. Staff A kept telling Resident #2 to "hold your . . . up"; "hold your . . . up"; and, "I hear scraping, hold your . . . up". Staff A kept telling Resident to hold his up during the transfer . . . to the resident's room from the dining room. Staff A at no time attempted to retrieve any type of footrest which placed Resident #2 at risk for falling out of his</p> | A 025               |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11963791</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/07/2020</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**WEINBERG VILLAGE LLC**

**13005 COMMUNITY CAMPUS DR.  
TAMPA, FL 33625**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 025                    | <p>Continued From page 2</p> <p>wheelchair. At 10:10am, Resident #2's room was observed and there were no footrests for the wheelchair observed in the resident's room.</p> <p>A record review for Resident #1, conducted on _____, revealed that Resident #1's Health Assessment Form dated _____ stated that the resident was at risk for _____ and required assistance with all activities of daily living. Resident #1 had _____ on _____, _____ (2 _____), and _____ Resident #1 did not have a Care Plan, Comprehensive Care Plan, Assessment, Investigation Form, or interventions implemented with each of the residents' _____ in the resident's record. Resident #1 was admitted to the Facility on _____.</p> <p>A record review for Resident #2, conducted on _____, revealed that Resident #2's Health Assessment Form dated _____ did not identify that the resident was at risk for _____ but did state that the resident had _____, difficulty walking, and was _____ and disoriented. Resident #2 had _____ on _____.</p> <p>The Facility did not obtain a new and updated Health Assessment when the resident had a change in condition and became a risk. Resident #2 required assistance with ambulation, bathing, _____, toileting, and transferring. Resident #2 did not have a Care Plan, Comprehensive Care Plan, Assessment, Investigation Form, or interventions implemented with each of the residents' _____ in the resident's record. Resident #2 was admitted to the Facility on _____.</p> <p>A review of the Facility's _____ Policy and</p> | A 025               |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11963791</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/07/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WEINBERG VILLAGE LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>13005 COMMUNITY CAMPUS DR.<br/>TAMPA, FL 33625</b>                           |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 025                                                           | <p>Continued From page 3</p> <p>Procedure, conducted on _____, revealed that the _____ Policy and Procedure stated that a resident "will be assessed for the risk for _____ upon admission, re-admission, semi-annually, and upon significant change" and "when a resident has a _____ for the first time ...a assessment MUST be completed". The _____ Policy and Procedure stated that "any resident with repeat _____ shall be re-assessed post _____" and that "the _____ assessment ...will be placed in the Care Plan" and "reviewed by the Director of Nursing team and incorporated into the Comprehensive Care Plan" and "the Care Plan interventions will be communicated to the [staff]". The _____ Policy and Procedures stated that staff must complete an incident report and a Change of Condition Assessment Form and that "a Post- _____ Investigation Form will be completed by the Director of Nursing" and "_____ precaution measures will be added to the Care Plan".</p> <p>A review of <a href="https://nursing-homelawyers.com/wheelchair-safety-website">https://nursing-homelawyers.com/wheelchair-safety-website</a>, conducted on _____, the website stated that resident "_____ as a result of injuries sustained by her when she was catapulted from her wheelchair as she was being pushed by an aide down the hall without the footrest in place" and "footrests are a commonsense safety device for use with wheelchairs to prevent serious lower extremity injuries".</p> <p>A review of <a href="https://journals.rcni.com/nursing-standard/to-use-a-wheelchair-without-the-footrests-is-bad-practice">https://journals.rcni.com/nursing-standard/to-use-a-wheelchair-without-the-footrests-is-bad-practice</a> -ns.20.30.39.s50 website, conducted on _____, the website referred to pushing "a patient in a wheelchair without the footrests in place is unsafe and uncomfortable for the nurse and the patient".</p> | A 025                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

|                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                          |                          |                                                        |
|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11963791</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/07/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WEINBERG VILLAGE LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>13005 COMMUNITY CAMPUS DR.<br/>TAMPA, FL 33625</b>                           |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 025                                                           | <p>Continued From page 4</p> <p>During an interview with Staff B, conducted on ..... (time not noted), Staff B stated that Resident #1 "tries to get up on her own and it doesn't work for her" and that Resident #1 "sometimes bears .....".</p> <p>During an interview with the Director of Nursing (DON), conducted on ..... at 02:08pm, the DON stated that "we have to look at what else we can do for [Resident #1]" and "we need to re-evaluate as to what's best for [Resident #1]". The DON stated that she does not complete any type of investigation for ..... or implement new intervention to prevent ..... The DON stated that she does not participate in any team meeting to discuss ..... occurrences and that there had been no discussion for a higher level of care for Resident #1.</p> <p>During an interview with the Assistant Administrator (AA), conducted on ..... at 02:17pm, the AA stated that places the information into the computer from the report. The AA stated that there were no ..... investigation forms and she didn't investigate the ..... or implement new intervention to prevent ..... from reoccurring. At 03:00pm, the AA was unable to provide Resident #1 or #2's Care Plan, Comprehensive Care Plan, Assessment, Investigation Form, or interventions implemented with each of the residents' ..... The AA stated that there had not been any meetings or discussions for a higher level of care need for Resident #1 and #2.</p> <p>Class III</p> | A 025                                                                          |                                                                                                                          |                          |                                                        |