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
	AL11964585	A. BUILDING: _____ B. WING _____	R 08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMELIA SPRINGS ASSISTED LIVING	1550 NECTARINE STREET FERNANDINA BEACH, FL 32034

(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 second revisit to a Change of Ownership survey was conducted at Amelia Springs Assisted Living from - . Deficient practice was identified during the survey.	{A 000}		
{A 165} SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality 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	{A 165}		

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{A 165}	Continued From page 1 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 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) [redacted], neglect, or [redacted] 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	{A 165}		

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{A 165}	Continued From page 2 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. (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 interview and record review, the facility failed file a preliminary report of an adverse incident to the Agency For Health Care Administration (AHCA) within one business day of its occurrence, involving one of three sampled residents, Resident #3. The findings include: Record review revealed an internal facility incident report dated . . . . . involving Resident #3. Per the report, on at 8:56am, Resident #3 sustained an unwitnessed with injury which caused an on right side of his forehead while trying to get up off the toilet. He was found by a facility staff member. The resident complained of left . . , . . . The resident was transported to a local hospital for evaluation and treatment. He was returned to the facility later the same day with report of no	{A 165}		

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{A 165}	Continued From page 3 significant injuries. Review of the medical chart for Resident #3 revealed a Resident Health Assessment for Assisted Living Facilities signed by a medical professional on . Per the assessment, the resident's diagnoses included: , , ataxia, , and , and ataxia were listed as his physical or sensory limitations. Memory loss is listed as or behavioral status. Special precautions included . The assessment also revealed Resident #3 required assistance with ambulation, , self-care (grooming), toileting, and transferring. During a telephone interview conducted with the Administrator on at 3;30pm, she confirmed the incident involving Resident #3. She acknowledged the facility's investigation report that was completed by the facility staff on . She confirmed the resident's was unwitnessed, he sustained minor injuries, and he was transferred to the hospital for evaluation and treatment. She stated she did not report the incident to agency because she did not think it was required based on verbal information she obtained from staff members after the incident occurred. She stated after the incident she interviewed staff members involved who verbally reported to her the resident's had not occurred in the bathroom as they had previously stated in the facility's investigation report, but rather in his room after getting up unassisted. She stated the resident had the right to use the restroom independently and therefore she did not deem it necessary to report the incident to the agency. She acknowledged the report should have been submitted. She also confirmed a follow-up investigation was not done nor were	{A 165}		

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{A 165}	Continued From page 4 there corrections made to the facility's previous survey findings because staff members involved had given her conflicting information. On . . . . . at 1:51pm, the Administrator was interviewed a second time about Resident #3. She explained Resident #3 was in rehab and she was awaiting an updated version of his Resident Health Assessment. Review of a second Resident Health Assessment, provided on , revealed he was visually , . . . , had . . . loss/. . . . . , and for Special Precautions, was marked as a risk. He needed assistance with all Activities of Daily Living (ADLs). The assessment was dated . . . . . Photographic evidence obtained. CLASS III	{A 165}		