

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965658	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/27/2025
NAME OF PROVIDER OR SUPPLIER PALM COTTAGES OF ROCKLEDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
CZ821	59A-35.110() FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPo rtal. 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPo rtal.	CZ821		

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965658	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/27/2025
NAME OF PROVIDER OR SUPPLIER PALM COTTAGES OF ROCKLEDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
CZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , which is hereby incorporated by reference and available	CZ821			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965658	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/27/2025
NAME OF PROVIDER OR SUPPLIER PALM COTTAGES OF ROCKLEDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
CZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780 , and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal . 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123 , and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal . 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	CZ821		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965658	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/27/2025
NAME OF PROVIDER OR SUPPLIER PALM COTTAGES OF ROCKLEDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
CZ821	Continued From page 3 to \$50 per day late not to exceed \$500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to submit an Adverse Incident Report electronically to the Agency within 1 business day after the occurrence of the incident for 1 of 3 residents sampled (#3). Findings: On resident #3 from her wheelchair and hit her on the dresser. She was transferred to the hospital where she was treated for a requiring . A review of resident #3 record revealed she was admitted on and discharged on . 1823 dated . She required assistance with ambulation and transfer. On at 4:40pm the Director of Nursing confirmed there was no Adverse Incident Report submitted to the agency. Unclassified	CZ821			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965658	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/27/2025
NAME OF PROVIDER OR SUPPLIER PALM COTTAGES OF ROCKLEDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	Continued From page 4	A 000			
A 000	Initial Comments A survey for complaint #202401 and generator monitoring were conducted on _____ at Palm Cottages of Rockledge Assisted Living Facility. There were deficiencies identified at the time of the survey.	A 000			
A 025 SS=G	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,	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965658	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/27/2025
NAME OF PROVIDER OR SUPPLIER PALM COTTAGES OF ROCKLEDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 025	Continued From page 5 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. This Statute or Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to provide adequate supervision and care and services appropriate to meet the needs to ensure safety through proactive measures to minimize the potential for and injuries for 3 of 3 sampled residents. Resident #3 who experienced with injuries. The facility failed to notify residents #1 and #2 primary care providers to obtain a treatment order for injuries of unknown origin. Findings:	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965658	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/27/2025
NAME OF PROVIDER OR SUPPLIER PALM COTTAGES OF ROCKLEDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 025	Continued From page 6 A review of the facility notes revealed resident #3 had 6 in 3 months. On at 2:39pm Nurse F documented an unwitnessed at 1:43pm. The resident was sitting on the bathroom floor. The resident reported she was trying to self-transfer to the toilet. No visible injuries. On documented at 2:49am by Nurse H. Resident had an unwitnessed at 2:15am. She was heard calling for help and was found sitting on the floor. She stated she was trying to get to the bathroom. Assisted into wheelchair x2 assist. No injuries noted. On documented at 10:12am by nurse I. Called to cottage, resident from wheelchair trying to stand up near her dresser. Hit her on the dresser causing a deep . 911 to hospital. Returned that evening with On documented at 8:38am by nurse J. The previous caregiver stated the resident twice that night. The resident said she by the side of her bed. She said she did not hit her . Complained of and was given. On documented at 5:35pm by nurse F. Witnessed at 4:55pm. Attempted to transfer to the dining room chair, missed the chair and landed on her right side. No injury noted. A review of resident #3 record revealed she was admitted on and discharged . Her record contained a Resident Health Assessment form (1823) dated . Her diagnoses included memory loss, tremors, and history of Mobility with wheelchair. She required assistance with ambulation, transfer, and toileting.	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965658	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/27/2025
NAME OF PROVIDER OR SUPPLIER PALM COTTAGES OF ROCKLEDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 025	Continued From page 7 On _____ in an interview with the DON she confirmed resident #3 had 6 _____ documented in 3 months. She could not provide any documentation of _____ mitigating strategies implemented for the resident to decrease and/or injuries. 2. On _____ at 10:10am resident #1 was observed in a high _____ wheelchair with a _____ -stained bandage on her right _____. There was no date or initials on the bandage. She was unable to say how or when the injury happened. A review of resident #1 record revealed she was admitted on _____. Her records contained an 1823 dated _____. Her diagnoses included a history of left _____, and _____, and _____. She was oriented x1 to self. She was under hospice care. She required assistance with ambulation, transfer, and toileting. A review of the facility notes found: On _____ at 9:35am documented by Nurse F _____ to right arm remains clean, dry, intact. 2pm staff informed writer that residents daughter requested for bandage to be changed due to soilage. _____ observed with _____ drainage. Resident did not tolerate _____ change as evidenced by _____ grimacing and tensing. Medicated with _____ prior to _____ change. On _____ at 6:21am nurse G daughter made aware of _____. Unsure what happened and skin is very fragile. On _____ at 3:56am nurse G documented resident has a _____ on right _____. Cleansed with normal _____ and covered with _____	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965658	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/27/2025
NAME OF PROVIDER OR SUPPLIER PALM COTTAGES OF ROCKLEDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 025	Continued From page 8 On _____ at 2pm an interview with nurse F was conducted. She said resident #1 daughter asked her to change the _____ on residents' arm yesterday (_____) around 2pm because it was soiled. The _____ that was on the arm was kerlex gauze and tape. She said it was applied by the night shift nurse. She said she put on a border gauze after cleansing the _____. She said she changed the _____ again around 11:40am today. Further review of resident #1 record did not find documentation of her primary care provider or hospice being notified. No order was found for treatment of her arm. On _____ at 4:30pm the Director of Nursing said Hospice comes today (_____) and she will document the treatment order. She confirmed there was no treatment order for resident #1 right arm. 3. On _____ resident #2 was observed in the common area seated in a wheelchair. She had an adhesive bandage on her left _____. There was a small black spot in the center of the bandage. No date or initials on bandage. A review of resident #2 record found she was admitted on _____. Her record contained an 1823 dated _____. Her diagnoses included _____, _____, and _____. She was oriented x1 to self. She was under hospice care and required assistance with all activities of daily living. Further review of her record did not find documentation of a _____ to her left arm or an	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965658	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/27/2025
NAME OF PROVIDER OR SUPPLIER PALM COTTAGES OF ROCKLEDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 025	Continued From page 9 order from her primary care provider for treatment to her left On at 3:15pm observed DON removing bandage from resident #2 left arm. A 1x1 inch was observed. Slight drainage noted. The DON said she did not know how long resident #2 had the injury or who put the on her. She confirmed the was not dated or initialed, which is standard practice. She confirmed there was no order for or treatment to the area. She said she would notify the primary care provider and the family. A review of the facility's policy dated found documentation to: Implement interventions when the resident remains a significant risk for Review of the facility Change in Condition policy dated : When a resident exhibits a change in condition, action will be taken to coordinate care. If Hospice is following contact the hospice nurse. (Photo Evidence Obtained) Class II	A 025			