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 _____	10/29/2025

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

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A 000	Initial Comments A complaint survey (CCR# 2025008511) and generator monitoring was conducted at Palm Cottages of Rockledge Assisted Living Facility on and . The facility did have deficient practices 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 records review and interview, the facility failed to follow its policy when 2 of 4 sampled residents (#1 & #2) had a that resulted in injury. Findings: 1. The facility's updated policy ( ) indicated that the facility would implement interventions when residents remain at a significant risk for . The nurse would instruct the unlicensed caregiver to initiate hourly checks. Review of resident #1's record revealed a date of	A 025		

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A 025	Continued From page 2 admission . Resident #1's health assessment 1823 signed and dated , it revealed a medical history of , ( ), , , , . Resident #1's 1823 did not reveal he was at risk for . On at 7:50 AM, licensed practical nurse (LPN) D documented that resident #1 was found on the floor in his room. There were no apparent injuries noted, and vital signs were taken and in normal ranges. All responsible parties were notified of the . Resident #1 was not sent out for a higher level of care. On at 5:53 PM, LPN- E documented that resident #1 was found on the floor between his bed and the bathroom door. Resident #1 stated that he was walking into the bathroom when he slipped and . Resident #1 sustained a to his right and , as well as an on his left . Vital signs were taken and were within normal ranges. All responsible parties were notified. Resident #1 was not sent out for a higher level of care. On LPN- C documented that resident #1 had an unwitnessed , he was trying to get out of bed by himself which caused him to slip and . Resident #1 was put to bed. Resident #1 was not sent out for a higher level of care. On at 12:24 PM in an interview with LPN- D she was asked what the facility's policy was and was she aware of the existing policy, she said yes. LPN- D stated if a resident should the staff is not to move the resident until a licensed individual arrives to assess the resident, vitals must be taken and if there is an	A 025		

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A 025	Continued From page 3	A 025		

issue the resident must be sent out to the hospital. LPN- D she stated that resident #1 was a frequent risk within the short span of time he had been in the facility. She stated that he was independent when he first got to the facility but over time he began to decline due to his condition. LPN- D said that his daughter was very present in his care and could not deal with the issue that her father needed to go to hospice services, and she stated many times that she was not ready to lose her other parent. LPN- D stated that resident #1 did about two to three times, but hospice would come in and evaluate him so he would never have to leave the facility because it was nothing of a critical nature.

On at 3:10 PM in an interview with LPN-E she was asked if she remembered resident #1, she said yes. LPN- E stated that he was not at the facility for long, maybe 3- months. LPN- E stated that he was independent when he first arrived, however he rapidly declined, his daughter was always at the facility going over his care with the RCC and hospice nurse. LPN- E stated that she remembers him taking a one evening, it was an unwitnessed , although he did have a to his and his . He did not have any other while she was on shift. LPN- E stated that resident #1 , sometime in . Resident #1's daughter was upset with knowing that her father was in the process of dying but every chance she got she would blame the facility and the staff. LPN- E stated that it was probably her way of dealing with his .

On at 10:29 AM in an interview with LPN- C she was asked about resident #1, she stated that he was pretty much independent but then his illness became aggressive. LPN- C was

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asked to elaborate, she said that when his illness began to progress, it was then that he began to not want to get out the bed, she stated that he was not a total care, however he needed an assist of 1 maybe 2 depending on the day. Otherwise, he was a good patient. There was a time that he still wanted to get up to move around and would not call nor ring for assistance which would sometimes end up in a . It was not anything that resulted in an injury that would warrant him having to be sent out for a higher level of care, he was also on hospice care. LPN-C stated that his daughter was always there, very protective of her father and a vocal person about his care and anything the facility wanted to implement in his care. LPN-C stated that resident #1's daughter did not want to accept that her father's condition was deteriorating, she was not preparing herself for what was to come.

2. A review of resident #2's record revealed the date of admission . Resident #2's health assessment 1823 signed and dated . It revealed a medical history of , , Type II , and , . Resident #2's 1823 revealed that she was assessed as a precaution.

On at 10:35 AM it was documented by an agency nurse resident #2 was found on the floor in her room. Resident #2 while getting out of her chair, upon falling she hit her on the dresser. There was a small cut noted on the of her . All parties notified. Resident #2 was not sent out to the hospital for higher level of care. All responsible parties were notified.

On at 8:29 AM it was documented by LPN - D that an unlicensed care giver observed resident #2 on the floor in her room with her

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against the night table. Resident #2 was holding the of her ; there were no open areas observed at the time. All responsible entities notified (Hospice, and family), vitals were within normal range.

On at 4:20 PM it was documented by LPN -D that resident #2 had an unwitnessed in her room. Resident #2 complained of her , hurting, vital signs were within normal ranges, all responsible entities notified. Will continue to follow plan of care and monitor the resident.

On at 8:54 AM Resident #2 was observed on the floor by the caregiver. Resident #2 denied hitting her however did complain of , , . LPN- D documented the resident did not have any upon assessment. All responsible parties notified, MD will monitor resident. LPN -D wrote will continue to follow resident's plan of care.

On at 12:36 PM the Resident Care Coordinator (RCC) was asked if the facility had conducted a risk assessment and what has the facility done to implement mitigating the on resident's #1 and #2? The RCC stated that the facility has not done a risk assessment on either resident. The RCC stated that the facility has not done an investigation on either resident. The which are experienced by the residents #1 and #2 were of their own doing, however the staff does report when residents incur and the resident is assessed by the nurse on duty, and if need be the nurse will notify hospice if the resident has that service and if they have an injury the will be notified so the resident can go out for a higher level of care. The RCC stated that resident #1 was independent when he first arrived at the facility but over a

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matter of weeks his health declined, and his daughter did not want to put him on hospice. Resident #1's daughter fought the idea of placing him on hospice until all providers made it clear that his condition was not going to change and he was actively dying.

On at 12:24 PM in an interview with LPN- D was asked what instance would initiate a care plan, she stated that a care plan would be initiated if a resident becomes a high risk or displayed any changes or a change in condition. The LPN-D was asked did the hospice nurses write their own notes and did the facility get a copy or a narrative of the third-party notes or were the notes kept at the nurse station or in the resident's room, she stated that they the hospice nurses wrote their own notes and kept the documentation in their folder, which was kept in the residents room. LPN- D stated that she was not allowed to update the resident's care plan only the RCC was allowed to do that. LPN- D was asked if resident 2's family visited frequently she stated yes, they were a very present family that visited the facility just about every day. LPN- D stated that resident 2's family never wanted her to be transported to the hospital, only if it were life threatening. The family stated that she has had many that resulted in hematomas so if her is not cracked open then she stays unless hospice or the physician says differently. LPN- D stated that resident 2 hit her and the family still refused to send the patient out. The LPN-D was asked who made the ultimate decision for the resident to be sent out to the hospital, she stated that hospice had the say so on the resident being sent out to a higher level of care. LPN-D was asked what the facility's policy was, she stated that the resident should not be moved until assessed by the nurse, then notify all responsible

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parties, and call for transportation should the resident require a higher level of care. The document the and write up the findings the RCC would implement to the resident's care plan.

The RCC was asked about resident #2 and the series of she had taken in the month of , (, , , ,). The RCC stated that the resident is an assist of 1, ambulates well and yes, she did have an episode of in , she has not once since. The caregivers are reminded to check on every resident throughout their shift, report all to the nurse or herself. The RCC stated that resident #2 was having some complications with a , and had to be placed on an , which could have contributed to her unsteady gait. The RCC was asked what the interventions were set in place for resident #2, she stated that the resident was reminded to call for assistance before getting up. Also, the nurses will remind the staff to make frequent checks on her because she is deemed a high risk. The RCC was asked if the facility has documentation of the caregivers conducting hourly checks, she stated no.

On at 1:45 PM the administrator stated that the RCC is new to the position and they are working towards getting the facility educated on how to minimize the . The administrator did confirm there was no internal documentation of a facility investigation into the which were experienced by residents #1 and #2. The Administrator did confirm the findings.

Photographic Evidence Obtained.

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