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
	AL11970305	A. BUILDING: _____ B. WING _____	09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND LIVING AT WELLEN PARK	19985 MARKET WAY VENICE, FL 34293

(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 for #2026016373 and generator monitor visit survey was conducted at Grand Living at Wellen Park on through . Deficiencies were identified at the time of 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	A 165		

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A 165	Continued From page 1	A 165		

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 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) , neglect, or , 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

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A 165	Continued From page 2 determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of 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 record review and interview, the facility failed to submit within 1 business day a preliminary report, and a full report within 15 days after the occurrence of an adverse incident through the Agency for Healthcare Administration (AHCA) portal for 1 (Resident #3) of 5 resident records reviewed. The findings included: Review of facility policy: X. Records Standards. Adverse Incident Reports.(no date). Policy: Adverse incident(s) and preliminary adverse incident(s) will be reported in a timely manner as required by the State of Florida Statute(s) which are confidential and develop a plan of action to correct and respond quickly to identify quality	A 165		

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A 165	Continued From page 3 differences. Procedure: When an adverse incident occurs, the following process will take place: The administrator or the Administrators designee shall submit by electronic mail the preliminary adverse incident report to the agency within 1 business day. The full and final report shall be provided within 15 days by electronic entry on AHCA website as required. An adverse incident is an event over which community personnel could exercise control rather than as a result of the resident's condition and results in the following: or of bones and joints. Any condition that requires the transfer of the resident from community to a un it providing more acute care due to the incident rather than the resident's condition before the incident. On , Record review showed Resident #3 had an admission date of with a medical diagnosis of unspecified , , of large without , or with . Record review of progress notes for Resident #3, showed on at 1:31 p.m., Resident #3 had a in the shower while being assisted by Resident Assistant ( ) Staff C. Resident #3 was transported by Emergency Medical Services to the Emergency Room. Record review of progress notes for Resident #3, documented on Resident #3 was still in the hospital with a possible discharge on .	A 165		

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A 165	Continued From page 4 Review of hospital records for Resident #3 showed Resident #3 was admitted on due to a of T12 - L1 (,) after a . Transfer to acute inpatient rehabilitation on due to significant functional decline. Record review of service plan for Resident #3 showed that effective , Resident #3 was scheduled every Tuesday and Friday to be physical assist for bathing by staff. On at 11:11 a.m., during an interview the Health and Wellness Director (HWD) said she was unaware and not told about the incident with Resident #3. She said if she knew about it she would have started the process of reporting it. The HWD said that she was planning on visiting Resident #3 in rehab to reassess him for return to the facility, as he is still there. On at 11:45 a.m., during an interview, LPN Staff B said she responded to the incident, called Emergency Services, and filed a report. Staff B said she did notify any of the nurse managers about the incident. She said they never respond anyway; anytime you call them you don't get a response so the nurses have been handling everything on their own. Staff B said incident reports are supposed to be checked by nurse management daily,and it should have been checked the next day. On at 1:35 p.m., during an interview, Resident Assistant Staff C said on , she was helping Resident #3 in the shower and he when she turned around to get a towel for him. On at 1:55 p.m., during an interview the	A 165		

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A 165	Continued From page 5 Health and Wellness director (HWD) said acknowledged an adverse incident should have been reported based on the parameters of the incident and the facilities policies and procedures. Class III	A 165		