STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966934	**06/17/2019**
NAME OF PROVIDER OR SUPPLIER **WHITE FLOWERS**	STREET ADDRESS, CITY, STATE, ZIP CODE **801 ARDENLEIGH DRIVE ORLANDO, FL 32828**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

Complaint Investigation #2019007498 was conducted on and . White Flowers had deficiencies at the time of visit.

0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on resident record review and interview, the facility failed to ensure the health assessment was accurate and complete for 2 of 4 sampled residents (#3 & 4).

Findings:

1. Resident #3's record revealed she was admitted to the facility . The health assessment report (1823 form), dated , was completed more than 60 days prior to admission to the facility. The 1823 form did not address the resident's needs regarding medications; that portion of the assessment was blank.

2. Resident #4's record revealed she was admitted to the facility . An undated 1823 form indicated she was a , , , had a , on her right heel, needed medication administration and needed total assistance with all the activities of daily living.

On at 12 PM, the administrator and staff A both said the resident was not a , , and did not need total care with her activities of daily living, and confirmed the 1823 form was incorrect.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on interview and record review, the facility failed to provide care and services appropriate to the needs of 1 of 4 sample residents who was , and was weak and the unlicensed staff failed to call emergency services (#3).

Findings:

Resident #3 was admitted to the facility on and discharged on . The health assessment report (1823 form), dated , listed diagnoses of , , , , , ( ), , , , , ( ) and, . Per assessment, she needed

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supervision with ambulation, eating, grooming, toileting and transferring; assistance was needed with bathing and . The 1823 form did not address the resident's needs regarding medications; that portion of the assessment was blank. The Long-Term Care Person Centered Plan, dated , indicated she was totally of and .

A progress note, dated and written in Spanish, indicated the resident returned to the facility at 12:30 PM. She and continued to complain she wanted to . Even with the assistance of a hospice aide, she could not sit in the walker; she sat on the sofa. The staff called her son and he came to the facility. He cleaned up the resident and did not allow staff to help him. At 3:17 PM, her , was . The resident's grandson called emergency services per son's request. The resident sat in the walker until emergency services arrived at 4:30 PM. The note read, "I did not call 911 because I thought the food she had for lunch did not suit her well."

On at 12:20 PM, caregiver A, the caregiver of this resident on , said the resident watched TV, ambulated with a walker. She was usually not a big talker and had some . She , asked her what was wrong, she said she wanted to . Caregiver A said she told the resident, "I will help you to the bathroom". She said she wanted to . Once I helped her to sit on the walker, she was heavy, she sat on sofa, then the hospice nurse (who was visiting resident #4) she held the walker and the resident sat in the sofa. The resident kept saying she wanted to ....she may have had movement on herself. She would normally would go in her brief even when in toilet. I assumed the lunch she had outside had not suited her well. She had pork chop, rice and black beans mixed. Afterwards I called her son, so he would know the mom . He said he was coming in a while. Once he came in, he said he needed to take her (resident) to bathroom. She had clear speech, not slurred. The son pulled her by the underarms to the bathroom. Once in bathroom she threw up again. He washed her with water. She kept complaining of wanting to . The resident's granddaughter came as well. The son a teenager, called 911. He did not allow me to help. He sat her in the walker. Rescue came at 4:30 PM. Before she was showered, she stopped . To me bad digestion.

On at 1 PM, the administrator said, "I spoke with her son. He said Don't come here you are the last person see her. If mom lives she would be paralyzed". The grandson came to pick things up (belongings). The grandson came , something was left beind he said she (resident) was fine.

Hospital record review on at 10 AM revealed the resident was taken to the Emergency room by ambulance on . She had increased , not feeling well and slurred speech. She was admitted on 19 at 4:18 PM with a diagnosis of right occipital and , infarct ( ). She remained hospitalized until and was transferred to a rehabilitation facility.

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Class II

0160 - Records - Facility - 58A-5.024(1) FAC

Based on facility record review and interview, the facility did not maintain an up to date admission and discharge log for 3 sampled residents (#1, 3 & 4).

Findings:

On at 9 AM, caregiver A said the census was 6 residents. The facility's admission and discharge log revealed the log listed 15 names. Six of the names had a discharge date and reason for discharge, but not where they went to. Three had date of discharge but no reason or location where they moved. Resident #4 was not listed as discharged, yet she no longer lived at the facility. Resident #3 was not listed as an admission or discharge. Resident #1 was not listed as an admission or discharge.

On at 11:30 AM, the administrator confirmed the findings.

Class III