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
	AL11910790	A. BUILDING: _____ B. WING _____	12/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PORT RITCHEY CENTER FOR ASSISTED LIVINC	5539 CHARLES STREET NEW PORT RICHEY, FL 34653

(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 (complaint numbers 2019015434 and 2019017934) was conducted at New Port Richey Center Assisted Living Facility on . . . . . New Port Richey Center Assisted Living Facility had deficient practice identified 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 must 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 shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 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 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	A 025		

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A 025	Continued From page 1 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 review, and interview, the facility failed to offer personal supervision as appropriate for each resident including monitoring of the quality and quantity of resident's body temperature, general health, safety and physical well-being of residents for one (Resident #1) of three residents sampled. Additionally, the facility failed to maintain a general awareness of the whereabouts for two (Resident#2 and #3) out of two residents who managed to elope from the memory care unit. Finding Included: 1. On a record review of the facility adverse incident report revealed on Staff A, Staff B, and the Wellness Director seen Resident#1 sitting up and alert on the memory care unit patio at 3:00 p.m. The adverse report confirmed Resident#1 was outside in heated conditions of 105 degrees from 3:00p.m until 5:50	A 025		

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A 025	Continued From page 2 p.m. At 5:50 p.m. she was observed by Staff A as unresponsive, , was rolling, was running, and skin was hot. At 5:51 p.m. staff called 911 and the resident was transported to the nearest local hospital. A record review of Resident#1 records (Health Assessment-1823) dated showed Resident#1 date of birth as . Resident #1 had a diagnosis of heat with history, advanced , and . During an interview with Staff B, conducted on at 3:48 PM he confirmed that Resident #1 was seated outside, on a couch, on the patio, at 3:00 PM at the start of his shift. He stated it was definitely warm that day, but he was not aware of the exact temperature. Staff B went on to say around 5:00 PM closer to 5:30 PM, Resident #1 was seen slouched over on her side. Staff B asked her if she was okay and called her by name but Resident #1 did not respond. On at 11:10 A.M., an observation of the memory care outside patio was observed, the outside patio was noted unscreened, it was apparent that where Resident#1 was seated while on the couch of the outside patio she would have been exposed to direct sunlight and extreme hot temperatures. A review of Emergency Medical Services ( ), Fire Rescue report, dated , for Resident #1, conducted on revealed the following: arrived at the facility at 6:07 PM and found Resident #1 lying on her left side on an outside bench. Her temperature was 106.4 degrees Fahrenheit. Her breathing was labored and she was responsive to , stimuli.	A 025		

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A 025	Continued From page 3 A review of hospital medical records dated . . . . . , for Resident #1 was conducted on revealed the diagnosis of heat . clinical . . , ... and uncontrolled high . . . . , . During an interview with the Executive Director (ED) on at 1:35 PM she confirmed that she was notified by the Wellness Director on that Resident#1 was on the outside patio couch and she had been sent out to the hospital because she was found unresponsive. The ED agreed the Wellness Director, Staff A and Staff B should have handled it differently. The ED stated, after 30 minutes if a resident is refusing to come inside, staff should try other alternatives. Resident #1 suffered a heat . . . . . and she was , . The ED was aware that the heat advisory for . . . . . was at temperatures of 105 degrees. 2. A record review of Resident#2 records (Health Assessment-1823) dated revealed Resident#2 had been diagnosed with . . . . . , and major . . . . . Resident #2 was listed as an elopement risk and resided in the memory care unit. During an interview with the ED on at 1:03 PM The ED confirmed Resident#2 was placed in the memory care unit for increased supervision on . . . . . Resident #2 eloped out of memory care on . The facility lawn care company left the gate open, they didn't shut it all the way, and the resident managed to get out. The ED stated, "she pushed the gate and got out." On . at 10:30 PM Staff A we	A 025		

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A 025	Continued From page 4 received a call from the local hospital that confirmed that they had one of their residents. - (Emergency Medical Service) told them that she was found less than a mile from the facility and transported by a good Samaritan. On at 1:45 AM after being treated for and , Resident #2 returned to the facility's Memory Care unit. On at 2:30 PM the ED accompanied surveyor on a tour of areas of memory care where Resident #2 managed to walk out of the facility. Surveyor observed a large white gate near the edge of the yard in memory care. At 2:36 PM, the ED stated, she initially believed Resident #2 pushed on the gate and walked out, however, later she discovered that Resident #2 was able to crawl under the fence and leave the premise, and managed to get almost a mile away. 3. A record review of Resident #3 records (Health Assessment-1823) dated showed Resident #3 was diagnosed with . Resident #3 was listed as an elopement risk and resided in the memory care unit. Resident #3's physical or sensory limitations were noted as " ROOM TO ROOM." Further facility record review conducted on revealed on the facility reported a resident elopement. In the outcome sections of report there was a check mark next to the following "Resident elopement, if the elopement places the resident at risk of harm or injury." The incident information section/investigation sections date of at 1:35 PM Resident#3 was last seen exiting the medication room by Staff E. At 2:41 PM the facility received a call by Law Enforcement stating Resident#3 was found by a Good Samaritan 0.2	A 025		

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A 025	Continued From page 5 miles from the facility. Thus from 1:36 PM until 2:40 PM, Resident#3 was missing and the facility had no idea or record of his whereabouts or that he was missing. On at 2:23 PM, an observation of the West side of memory exit door was observed with the ED. The ED explained that the door alarm wasn't working properly on . . . . . Therefore Resident #3 was able to wall down to the end of the hallway while in memory care and push and hold the handle for 15 seconds and the door popped open. The ED confirmed no alarm went off to alert the staff. Resident #3 walked out of memory and on to, the outside area which led him directly to a main sidewalk where he managed to walk 0.2 miles. Class II	A 025		