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
	AL11964952	A. BUILDING: _____ B. WING _____	11/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF SARASOTA	5509 SWIFT ROAD SARASOTA, FL 34231

(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 An unannounced complaint survey for complaint #2019013830 was conducted through at Arden Courts of Sarasota, an assisted living facility in Sarasota, Florida. Complaint #2019013830 was substantiated at tag A0025. The following is description of the deficiency.	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,	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 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 record review and staff interview, the facility failed to provide personal supervision for 1 (Resident #1) of 1 resident reviewed. This resulted in Resident #1 exiting an unlocked dining room door into a secured courtyard at 11:00 p.m. at night. The findings included: On , record review revealed on Resident #1 exited the facility through a dining room door that had been left unlocked into a secured courtyard. She was found at 10:55 p.m., in the secured courtyard. The facility is a locked memory care facility. On at 1:35 p.m., in an interview with the Resident Services Coordinator (RSC) she	A 025		

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A 025	Continued From page 2 confirmed Resident #1 did enter a secured courtyard through an unlocked door on . The adverse incident report analysis completed by the facility concluded a caregiver failed to lock the door the resident exited from and the corrective action was disciplinary action for that employee and retraining for the licensed nurses and caregivers related to lockdown procedures. In addition, the report stated the evening and night licensed nurses are checking all doors to ensure they are locked. Retraining was not initiated until . . . . . and was only provided to 15 staff of which only 2 primarily worked the evening/night shift. There were approximately 33 licensed nurses and caregivers employed at the facility on the date of the incident and there was no evidence the remainder were retrained. There was no evidence the employee identified as not locking the door ever received any disciplinary action. On . . . . . , the RSC initiated a new form to be completed by the 7:00 p.m. to 7:00 a.m. licensed nurses. The form is a security checklist that is to be completed hourly and includes: checking that all exterior doors are locked, checking that exterior doors from the dining room and community center are locked and courtyard checks are completed timely. Review of the form revealed since initiation of the form on . . . . . , the form was not completed on 36 days or was only partially completed on another 36 days. The form was only 100% completed on 20 days since . . . . . . On . . . . . , at approximately 1:45 p.m., in an interview the RSC confirmed the licensed nurses had not been completing the security checklist as required, therefore there was no documented	A 025		

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A 025	Continued From page 3 evidence the exterior doors were being checked as required. She also confirmed retraining was not completed for all licensed nurses and caregivers and confirmed only 2 staff on the evening and night shift had received the required retraining. Class III	A 025		