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
	AL11969015	A. BUILDING: _____ B. WING _____	05/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTON PLACE	501 S WALTON AVE TARPON SPRINGS, FL 34689

(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 number 2020008649) was conducted at Walton Place on . There were deficiencies at the time of the survey.	A 000		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 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 acute care due to the incident rather than the resident's condition before the incident; or	A 165		

AHCA Form 3020-0001

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

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A 165	Continued From page 1 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, by electronic mail, facsimile, or United States 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, by electronic mail, facsimile, or United States 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) [illegible], neglect, or [illegible] 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 determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of	A 165		

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A 165	Continued From page 2 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. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on interviews and records reviews, the facility failed to file adverse incident reports with the state, for events or conditions that required the transfer of a resident from the facility to an emergency room or a unit providing more acute care, for events that were due to the incidents,	A 165		

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A 165	Continued From page 3 rather than the residents' conditions prior to the incidents, for 2 of 3 residents whose records were reviewed (Resident #1 and Resident #3). Findings Included: At 10:15am on [redacted], a request was made to the Resident Care Director of the facility regarding whether or not the facility had any adverse incident report records (AIRS). The Resident Care Director firmly stated they had not filed any AIRS. The Resident Care Director then provided the facility's policies and procedures regarding incident reporting. A review of the facility's policies and procedures for incident reporting was conducted on [redacted]. The policy stated that all incidents should be reported immediately to the supervisor on duty and the supervisor will determine what steps to be taken. Is it major or minor? If major, the supervisor will call the Administrator immediately. The policy included the following guidelines for determining if an incident would be considered "adverse": hospitalization of a client, emergency room (ER) visit of a client, [redacted] of a client if not due to natural causes, and any condition that required the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the condition before the incident. The policy and procedure included specified time frames for filing with the state electronically, within 24 hours. The policy stated that "everything else would be minor". A review of Resident #1's record was conducted on [redacted]. The review revealed that charting notes dated [redacted] at 8:14am, by Staff C, stated that 911 was called as staff alerted the front desk that Resident #1's [redacted] and [redacted] were [redacted].	A 165		

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A 165	Continued From page 4 and the resident had slurred speech and excessive drooling. Staff C notified the primary care provider, a 3rd party provider and the resident's representative. The emergency management system transported the resident to a nearby hospital emergency room. There were no further notes in the resident's chart about what the outcome of the emergency room visit was, or anything further to do with the resident's condition. There was nothing in the record to suggest that the facility had followed up with the hospital or filed any incident report. An attempted review of an adverse incident report revealed that the facility failed to file one with the state. An interview was conducted at 1:20pm on [redacted] with the Resident Care Director, who stated that on [redacted] the staff alerted him early in the morning that there was something wrong with Resident #1. He stated he observed the resident with a [redacted], sticking out [redacted] and the resident was flushed and drooling. The Resident Care Director stated that, at the time, he thought it was an [redacted] reaction, but wasn't sure what the reaction would be from. He stated he did not know what was going on. He stated an emergency management technician told him that it looked like a [redacted]. The resident was then taken to hospital. He stated that, later, a hospital representative told him the resident may have had a [redacted]. As of [redacted], Resident #1 appeared on the facility's resident roster on [redacted], marked as out of facility. At 4:00pm on [redacted], an interview was conducted with a 3rd party provider nurse who had knowledge of Resident #1's health. The nurse stated that recently Resident #1's medications were changed and that she had given the resident the first dose of a new	A 165		

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A 165	Continued From page 5 long-acting medication on [redacted]. On [redacted], the facility called her to inform her that Resident #1 had a [redacted] and was drooling and flushed and not doing well. According to the nurse, her first thought was that there may have been an adverse reaction to the new medication. The 3rd party provider nurse was not provided with any further information, after that, regarding Resident #1's condition either from the facility or the hospital. Resident #1's hospital records were requested, however not received by [redacted] due to the hospital's policy of not releasing records of any admitted patient who was still in the hospital. As of this writing, Resident #1 entered the hospital on [redacted] and was still there on [redacted]. A review of Resident #3's record was conducted on [redacted]. Resident #3's record revealed that on [redacted] the resident called 911 and was taken to the hospital. The record also revealed an internal incident report on [redacted] at 12:45am, which stated the resident called 911 for medical assistance, the resident "did not feel well after taking her medication" and wanted to go to the emergency room for medical assistance. A review of Resident #3's hospital records revealed that the resident was transported to the hospital ER on [redacted] by the emergency management services with a chief complaint of [redacted]. The hospital records revealed that Resident #3 was not admitted to the hospital but instead was returned home. According to an attempted records review, the facility did not file an adverse incident report for this incident where a resident was transported to an ER. An interview was conducted with the Resident Care Director at 1:20pm on [redacted]. According to	A 165		

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A 165	Continued From page 6 the Resident Care Director, Resident #3 was manipulative. The resident called 911 and reported that the facility was giving medications improperly. The Resident Care Director stated that Resident #3 did not return to the facility after leaving for the emergency room on , but he was not sure why. As of , Resident #3 appeared on the facility's resident roster, however the resident was marked as "out of facility" and the health status of the resident was said to be unknown. Photographic evidence obtained. Class III	A 165		