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
	AL11969543	A. BUILDING: _____ B. WING _____	C 08/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE VERANDA AT LADY LAKE	955 S HWY 27/441 LADY LAKE, FL 32159

(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 investigation, complaint numbers 2020012075 and 2020012089, and an control monitoring survey were conducted at Village Veranda at Lady Lake on and . The facility had deficiencies.	A 000		
A 030	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close	A 030		

AHCA Form 3020-0001

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

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A 030	Continued From page 1	A 030		

proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and , ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and universal precautions; and,
8. The requirements for coordinating the delivery of services to residents by third party providers.
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.

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A 030	Continued From page 2 (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence,	A 030		

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A 030	Continued From page 3	A 030		

autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , , , , , , , , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency

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A 030	Continued From page 4 relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility	A 030		

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A 030	Continued From page 5 must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and . . . . , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow their resident . prevention policy by not completing an incident report for an . . . . . allegation to determine the circumstances of the event and institute and document appropriate measure to prevent similar future occurrences for 1 of 3 residents, Resident #1. The facility also failed to follow their prevention policy by not reporting a suspected physical assault to local law enforcement for 1 of 3 residents, Resident	A 030		

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A	Continued From page 6 #1. The facility failed to safeguard residents' well-being by not following current control standards related to COVID-19 and Agency for Health Care Administration (AHCA) Notice, Residential and Long-Term Care Facilities to Implement Universal Use of Masks, dated , for 5 out of 5 staff working in the memory care unit, Staff A, B, C, D, and E. Findings: 1. A review of the policy titled "Prevention and Reporting of Resident " revised , read, "V. Special Information. , and/or suspected must be reported to the Executive Director immediately. In addition to this responsibility you are required by law to follow the procedure below: VI. Reporting Duties. When any employee of the Community has reasonable cause to believe that a adult has suffered , neglect or abandonment, he or she shall report the incident to the Elder Hotline from the time the determination has been made that the reportable incident occurred. * An employee who observed the incident or hears the victim state it happened. * An employee who hears about an incident from a permissive reporter with direct knowledge of the incident. A permissive reporter is a visitor or family member. * The Executive Director receiving the information from a mandated reporter. The mandated reporter reports whenever there is cause to believe or suspect, with reasonable cause, an incident or , abandonment,	A 030		

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A 030	Continued From page 7 neglect or financial . , ... has taken place. If the employee has reason to suspect an incident is or physical assault, report to the local law enforcement agency and to the hotline number. The mandated reporter will prepare an incident report for any . . . . , neglect or . , ... to determine circumstances of the event and institute and document appropriate measures to prevent similar future situations." A review of an anonymous allegation revealed Resident #1 was alleged to be , , . . . , by Staff H, (Resident Associate) who 'stuffed' . . . . . care wipes in the resident's , . A review of the facility's event incident reports revealed there was no incident report completed for the allegation of on . An interview was conducted with Staff F, on . . . . at 3:45 PM. Staff F stated, "We were changing her, [name of Resident #1], me and [name of Staff G,] and [name of Staff H,], I was on the same side of bed as [name of Staff H], I was by her . . and [name of Staff H] was by her , resident was rolled toward me and [name of Staff H]. [Name of Staff G] was looking down and wiping the resident's bottom. Resident #1 did not like [name of Staff H]. At beginning of care, she told [name of Staff H] to get out. She was yelling and screaming at [name of Staff H] and [name of Staff H] shoved two care wipes in her . . . . [name of Resident #1] pulled them out and said, 'she was trying to kill me.'"	A 030		

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A 030	Continued From page 8 An interview was conducted with the Assistant Executive Director on at 3:15 PM. She stated law enforcement was not called because Resident #1's niece said not to call. An interview was conducted with the Executive Director on at 5:30 PM. He confirmed the facility did not do an incident report. He confirmed that the facility policy is to complete an incident report. 2. A review of the facility's COVID-19 Procedure Manual read, "Monitoring and Screening of Residents. Actively monitor and assess residents for and symptoms of , , , including temperature checks and , oximetry twice daily. , , symptoms may include new or worsening malaise, , , or . Identification of these symptoms should prompt isolation. ... Preventing Illness. If there is concern of COVID-19, then N95 masks must be used in place of standard 3-ply surgical mask. ... Isolation. Staff entering the high-risk resident's room is required to wear an N95 mask, gloves, , protection, and gown. All Personal Protective Equipment (PPE) is to be disposed of inside the room near the exit in a red biohazardous bag or laundry bag that can be sanitized and washed." A review of the AHCA Notice, Residential and Long-Term Care Facilities to Implement Universal Use of Masks, dated , , revealed, "Effective immediately staff of residential and long-term care facilities are to implement universal use of masks while in the facility. ... Staff in a room with a patient with , , symptoms of unknow cause or a patient with known or suspected COVID-19 should adhere to Standard, Contact, and Droplet Precautions ... This includes wearing ...N95	A 030		

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A 030	Continued From page 9 mask (as fitted and available - if not available, at least a mask)." A list of residents on isolation precautions and residents under investigation for the COVID-19 was reviewed. The list revealed that Resident #5 tested positive for COVID-19 and was on droplet precautions. Resident #6 had symptoms and was under investigation for COVID-19. On at approximately 10:10 AM Resident #6, a person under investigation for COVID-19, was observed in the living area seated in a wheelchair at a table participating in an art and crafts activity. The memory care resident was not wearing a mask. Staff A, Memory Care Activities Coordinator, was seated next to Resident #6 with a cloth covering, not the mandated N95 mask. An interview was conducted with the Director of Resident Services on at 10:15 AM. She stated that Resident #5 tested positive for COVID-19 and Resident #6 was with a of 100.8 degrees Fahrenheit and a . She stated the Memory Care Unit census was 20 and 18 residents were COVID-19 negative. On at approximately 10:17 AM Resident #5 was observed in his room seated on his bed. There was no sign outside the door warning of isolation or Personal Protective Equipment (PPE). An interview was conducted with Staff B, Licensed Practical Nurse (LPN) on at 11:15 AM. Staff B stated that Resident #5 and Resident #6 should be on isolation precautions.	A 030		

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A 030	Continued From page 10 On . . . . . at 11:50 AM, an observation in the memory care unit was conducted. The room for Resident #5, a resident positive for COVID-19, had no container of PPE outside or inside of his room. There was no signage on Resident #5's door to indicate droplet precautions. Staff in the memory care unit were observed wearing surgical masks. Resident #6 was observed in the dining room sitting at a dining room table for lunch. An interview was conducted with the Director of Resident Services on at 12:16 PM. She stated that the staff [Staff A, Memory Care Activity Coordinator; Staff B, Licensed Practical Nurse; Staff C, Medication Technician; Staff D, Resident Associate; and Staff E, Licensed Practical Nurse] did not wear N95 masks when providing care for Resident #5 and #6. She stated the facility did not have N-95 masks. She stated that they keep PPE at the nursing station not at the room. She confirmed there was no sign on the door to indicate the resident was on isolation. She confirmed that Resident #6 should be in her room as she has symptoms and her COVID-19 test results had not been received. An interview was conducted with the Director of Resident Services on at 12:16 PM. She stated that the facility does have N95 masks. Class II	A 030		