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
	AL11965351	A. BUILDING: _____ B. WING _____	08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA LUTZ	414 CHAPMAN ROAD EAST LUTZ, FL 33549

(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 2020014300) was conducted at Atria Lutz Assisted Living Facility on with a focused control visit and a generator monitoring. Deficiencies were identified at the time of survey	A 000		
A 025 SS=G	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 provide supervision and oversight required for each resident to include awareness of safety and wellbeing for 1 (Resident #1) of 9 residents in the facility's memory care unit. The lack of oversight and awareness led to Resident # 1's hospitalization after prolonged exposure to temperature above 90 degrees Fahrenheit in the facility's memory care Balcony and placed residents of the memory care unit at immediate risk of harm. Findings include: A review of Resident #1's hospital record conducted on . . . . . revealed that on Resident #1 was found by a staff member outside of the facility. Resident #1 was unable to stand and was very weak. The records revealed that staff called 911 and Emergency Management Services ( ) arrived at the	A 025		

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A 025	Continued From page 2 facility. Resident #1's temperature was 103.5 degrees Fahrenheit upon arrival and Resident #1 was transported to a local hospital, where he was admitted. Further review of the Resident #1's hospital record conducted on revealed Resident # 1's chief complaint was , suspected , first degree sunburn of arms and , and acute , injury. Resident #1 was discharged on . An observation was conducted on beginning at 10:45am of the memory care unit balcony/patio on the second floor of the facility where Resident #1 was found outside. An open area was observed with no roof, no fans and hydration station observed. A review of Accuweather from https://www.accuweather.com/ conducted on , revealed that in Lutz, Florida on the temperature was 93 degrees. An interview with Staff A was conducted on at 11:39am. Staff A stated she and her coworker were providing direct care in residents' room, and residents were left unsupervised for during this time. Resident #1 was observed sitting at dining room table before staff left the floor. Upon return to the floor staff noticed Residents not at dining room table and went to look for him. Resident #1 was noticed outside on a chair, encouraged resident to come into the facility. Resident #1 went to stand up and buckled he was assisted to the ground and 911 was called. In an interview with the Administrator conducted on at 1:05pm, she stated she received a	A 025		

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A 025	Continued From page 3 call informing her that the resident (Resident #1) had been hospitalized due to . She met and discussed the event with Staff A and staff confirmed her statement that the floor had been left unattended while she and a coworker were in residents' rooms. There is nothing in writing that the staff have been instructed to be aware of the whereabouts of the residents, to often, and to redirect the resident into the facility from the patio. She discussed it with them, but nothing formal had been implemented. We have discussed with the staff that if they must leave the floor to give direct care that they should call the manager on duty (MOD) to cover the floor. We haven't put any of this in-place as of right now. There had not been any new staff training since the incident. An interview conducted on at 1:50pm with the Memory Care Director, he stated that he was not sure if and in-house incident report had been completed. He also stated that the staff did not have any in-services on supervising or hydrating the residents while in patio. An interview conducted on at 1:58pm with the Administrator, she stated that an in-house incident report had not been completed and there was not documentation that the physician or family was notified. She stated that she returned from vacation on Monday and it did not occur to her to do an Adverse Incident Report. She stated that a formal in-house investigation had not been conducted at this time. There has been a verbal investigation, but nothing was documented. During a phone interview on at 5:06 pm the Administrator called and stated that there was a camera on the patio that revealed that the	A 025		

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A 025	Continued From page 4 subject of compliant had been out on patio at noon and the staff had not gone out until 3:45pm. On at 5:19pm, a telephone interview was conducted with the Administrator. She stated that she finally reviewed the camera recording. She saw that the resident went outside a little after 12:00pm, no staff went out to check on him until 3:45pm. At this time, the staff went to go check on him because they had to take his temperature. The reason they were taking his temperature is because they check all the residents temperature two times a day as a monitoring for COVID. Class II	A 025		
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:	A 165		

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A 165	Continued From page 5 1. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] 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 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	A 165		

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A 165	Continued From page 6	A 165		

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 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),

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A 165	Continued From page 7 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 record review and interview, the facility failed to file an Adverse Incident Report for 1 (Resident #1) of 1 sampled, which must be submitted within one business day after the incident occurred. Finding included: An attempted record review conducted on , revealed that an adverse incident report had not been completed for an event that occurred on for Resident #1 for which the resident to be transferred to the local hospital. An interview conducted on at 1:58pm with the Administrator, she confirmed that an adverse incident report had not been filed for Resident #1 incident for . Class III	A 165		