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
	AL11968608	A. BUILDING: _____ B. WING _____	09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS GARDENS SENIOR RESIDENCE	17250 SW 137 AVENUE MIAMI, FL 33177

(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 COVID-19 control and generator survey was conducted at Seasons Gardens Senior Residence on through . . . . Deficiencies were identified at the time of survey.	A 000		
A 030 SS=J	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 proximity to a telephone accessible by residents	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		

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. [illegible] and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and [illegible];
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.
(g) In addition to the requirements of section

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A 030	Continued From page 2 429.41(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, autonomy, and interaction within the community.	A 030		

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A 030	Continued From page 3 (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 [illegible] for health care services, the provision of or arrangement of transportation to health care [illegible], 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 [illegible], the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for	A 030		

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A 030	Continued From page 4	A 030		

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 must ensure a resident's access to a telephone to

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A 030	Continued From page 5 call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and [illegible], 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 [illegible] or [illegible] 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: Seasons Garden 0030 Based on observation, interview, and record review, the facility failed to honor resident's rights to receive adequate and appropriate health care for one out of 34 residents (Resident #1). Resident #1 after staff found her unresponsive, and no staff attempted to perform [illegible] ( ) on her. The facility also failed to safeguard residents' well-being by failing to follow current	A 030		

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A 030	Continued From page 6 control standards related to COVID-19 and Florida Governor's emergency orders DEM Order 20-006, dated . . . . . Staff were observed not wearing Personal Protective Equipment (PPE) while caring for confirmed COVID-19 residents. Findings included: 1. A review of the facility's record showed Resident #1 . . . on . . . . . Review of Resident #1's progress notes dated . at 11:00 AM noted that Staff B found Resident #1 unresponsive and called 911. Resident #1's progress notes dated . . . . . at 11:15 AM also noted that Staff reported that was provided prior to 911 arrival. Interviewed on . . . . . at 11:02AM Staff E stated, regarding Resident #1, on he received a telephone call from Staff B informing him that Resident #1 was found unresponsive during rounds before the shift ended. Her vitals were checked, she did not have a , and 911 was called. The agency representative asked the nurse, what else should have occurred? Staff E stated, "If you are referring about . . . , the staff did not give because the resident looked like she . . . earlier". On . . . . . at 03:44 PM, during a telephone interview Staff B stated on at around 10:30PM, she and Staff C entered Resident #1 room and saw her laying on her side with . . . . . out of her . . . . near her . . . . . Staff B stated that Staff C checked Resident #1's , and she and Staff C yelled out to the resident, but the resident was unresponsive. Staff B stated that	A 030		

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A 030	Continued From page 7 she left the room to call 911 and the administrator. She stated, within ten minutes she returned to the room and saw Staff C and Staff D standing by the resident's bedside. She stated the resident was still laying on her side with [redacted] out of her [redacted]. Staff B stated that fire rescue arrived about five minutes later and the resident was still in same position. Staff B further stated that she believed Staff C performed [redacted], but she did not see her because she left the room. When asked how long a person who is certified must perform [redacted] on an unresponsive individual, Staff B stated, 'between 15 to 20 minutes.' Staff B further stated that on [redacted] Resident #1 was laying on her side the last time she went to the room at around 07:30 PM. She stated that herself, Staff C and Staff D found Resident #1 in the same position when they entered the room at around 10:30 PM. On [redacted] at 01:20 PM Staff C stated on [redacted] at around 10:30PM, she left Resident #1 room and went to call 911 while Staff B remained in the room to perform [redacted]. Staff C stated that she did not witness Staff B performing [redacted] on Resident #1. On [redacted] at 9:31AM Staff C stated that she did the last round at 07:25 PM to 07:30 PM and went to Resident #1 room. She stated that Resident #1 was laying on her side, talked to her and asked to turn on the TV. Staff C further explained on [redacted] at around 10:30PM herself, Staff B and D conducted rounds, went to Resident #1 room and found her unresponsive. Staff C stated, herself, Staff B and Staff D started performing [redacted]. Staff C stated that they could not put Resident #1 on the floor because she was too heavy.	A 030		

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A 030	Continued From page 8 On at 10:30 AM, Staff D stated on that she believed Staff B performed on Resident #1, but she did not witness it. She stated she left the room and went to attend to another resident. A review of the ambulance records dated showed rescue was dispatched to the facility on at 10:53 PM. The record noted that Resident #1 was found purple, , stiff and upon arrival. The ambulance records also noted that staff reported they last saw Resident #1 alive on at 06:00 PM. Review of the facility ( ) policy & procedures revealed "it is the policy of the facility that a shall be filed whether it was executed or waived. A label should be conspicuously pasted on the resident record. The facility should follow procedures and honor a properly executed . In the event a resident experiences , staff trained in ( ), or licensed health care provider present in the facility, may withhold ." A review of Resident #1's records dated revealed that there was no on file. There was no documentation that the resident did not wish to receive medical care if she was found unresponsive. 2. A review of the facility records dated	A 030		

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A 030	Continued From page 9 showed a census of 23 residents. Review of the COVID-19 test results showed 19 of the 23 residents were positive and four residents were negative. On at 8:16AM Staff E stated that the COVID-19 positive residents were located on the facility's west wing and the COVID-19 negative residents were located on the East wing. A review of the COVID-19 staff test results dated from through showed 11 of 31 staff, (Staff A, B, D, F, G, H, I, J, K, L, M tested positive. Five staff, (Staff A, D, F H and I had a medical clearance to return to work. Observation on at 8:57 AM on the west wing showed Staff F feeding Resident #4. Staff F was not wearing gloves and was therefore exposed to the resident's saliva. A review of test results showed that Resident #4 was confirmed positive for COVID-19. A review of the facility's COVID-19 staff test results showed Staff F tested positive on and did not have a medical clearance to return to work. On at 10:57AM, observed Staff G arrive at the facility. He stated the facility called him to come and turn on the generator. He also stated he was positive for COVID-19 and confirmed that he had no medical clearance to return to work. Observation on at 8:39 AM showed Staff E on the west wing not wearing gloves and feeding Resident #3 and was therefore exposed to the resident's saliva. A review of test results showed that Resident #3 confirmed positive for COVID-19.	A 030		

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A 030	Continued From page 10 On at 8:39AM, observation showed a box of gloves in the hallway near each nurse's station. On at 9:04 AM Staff E, a Registered Nurse, stated that any staff who provided care to residents in the isolation area, including feeding residents, must wear gloves, along with N95 masks, shield and gowns. A review of the facility's COVID-19 staff test results showed Staff E tested negative on . . . . and . However, on , two days after being observed caring for a COVID-19 positive resident without wearing full PPE as recommended by the Centers for . . . Control, Staff E tested positive for the illness. Class 1	A 030		