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
	AL11911654	A. BUILDING: _____ B. WING _____	09/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OPAL AT CAPE CORAL	4920 VICEROY COURT CAPE CORAL, FL 33904

(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 survey for complaint #2020014851, focused control and emergency power plan monitoring was conducted on at The Opal of Cape Coral, an assisted living facility in Cape Coral, Florida. Complaint #2020014851 was substantiated at A0025. The following is a description of the deficiency.	A 000		
A 025	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	A 025		

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A 025	Continued From page 1 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 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, interview and review of hospital and emergency management services ( ) records, the facility failed to provide adequate supervision for 1 (Resident #1) of 1 resident to maintain a general awareness of the resident's whereabouts. Failure to provide adequate supervision resulted in heat exposure/heat . . . and transfer to acute care facility. The findings included: Record review of the resident's progress notes revealed on . . . . . , Resident #1 was found outside . Review of further documentation in the facility,	A 025		

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A 025	Continued From page 2 the Resident Incident Report revealed on . . . . the resident was found . . . . outside in the courtyard, sitting in a chair but slumped to the side, vital signs obtained and documented the resident with a body temperature of 106.1 degrees, and resident was transferred to hospital. On at 11:30 a.m., in an interview, Staff A stated on the day of the incident, the last time she saw Resident #1 was at breakfast, she stated the next time anyone saw the resident was when she was found unresponsive in the courtyard by staff searching for her for the lunch meal. She said if Resident #1 went out into the courtyard, she would not be able to get . . . into the facility by herself and when staff are aware of residents in the courtyard, they are to check on them every minutes, however if staff don't observe residents going out in the courtyard, they don't check the courtyard. She said she did not observe any cups or bottle of water outside with Resident #1 when she was found. On at 12:30 p.m., in an interview, the Activities Director stated she remembers Resident #1 having had breakfast and going to . . . . . , , that day which started at 10:00 a.m., but does not recall if she stayed for the entire activity. She said if she is busy, she would not always walk by the courtyard and check to see if anyone was in the courtyard. On . . . . . at 12:45 p.m., in an interview, Staff B, stated she is not sure how the resident was able to go outside in the courtyard without staff knowing as she was assigned to be checked on hourly for wellness checks, by the staff member assigned to work the floor that day. She stated she did not observe any cups or bottle with water next to the resident when she was found in the	A 025		

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A 025	Continued From page 3 courtyard. Review of the hospital records documented on at 12:24 p.m., revealed notes of physical examination of Resident #1 documenting, skin warm and dry, patient appears to have consistent with sunburn on her thighs and lower abdomen and arms. First degree, no second . On at 1:30 p.m., in an interview, the Assistant Executive Director, stated staff are to make rounds to check to see if residents are outside in the courtyard and check on them every minutes, making sure they have water and are safe. She verified Resident #1 was receiving assistance with care/wellness checks to be performed by staff every 2 hours, she stated she does not recall if the resident was receiving hourly wellness checks by staff, she confirmed care/wellness checks for Resident #1 were never performed on that day. On at 2:30 p.m., in an interview with Agency Licensed Practical Home Health Nurse, she stated she offered assistance to the staff when they found Resident #1 unresponsive in the courtyard, she performed an assessment of her vitals, which included a body temperature check which revealed a reading of 106.1 degrees. She said the resident's skin was warm to touch and she was , and she did not observe any evidence of water next to the resident or the chair she was found sitting in. On at 3:05 p.m., in an interview, the Regional Director stated residents would come and go into the courtyard when they please, and staff would provide water if they noted the resident outside. She stated staff would know if	A 025		

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A 025	Continued From page 4 the residents were outside in the courtyard when they walked by and saw them outside. She stated there really is no staff assigned to monitor residents going into the courtyard. Review of the facility policy related to residents outdoors, revealed the following information: It is the policy at Opal Senior Living that residents be allowed out into the courtyard to enjoy fresh air. The policy goes on to state in the procedure: 3. . . . water and shade will always be available to the residents who wish to sit outside. 4. Wellness staff will conduct regular rounds and verbally confirm wellness of residents outside. Review of records revealed notes documenting on . . . . upon arrival found Resident #1 under the care of the fire department, the resident was found lying outside in the sun and heat, Resident #1 was unresponsive and appeared to be suffering from , the resident was hot to touch, skin pale and dry, temperature 107 degrees, resident appears , no one from assisted living facility can tell . . . how long ago or even how the patient got outside. In an interview with an paramedic on . . . . at 4:00 p.m., he stated he was the medic in charge on the day they were dispatched to the facility, and when he arrived at the facility staff were unable to tell him how the resident got outside the facility or how long she was outside. He stated Resident #1 had signs of severe . . . . . , with a body temperature of 107.1 degrees, her clothing was hot on her body and her skin was hot to touch and pale, she was unresponsive, and tachycardic which are signs and symptoms of . . . . . , he stated the resident also had sunburn on her body, her skin	A 025		

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A 025	Continued From page 5 appeared to have been . . . . . through her clothing. Class II	A 025		