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
	AL11969637	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEARDED OAKS PLACE	60 BEARDED OAKS DR SARASOTA, FL 34232

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A 000	Initial Comments An unannounced change of ownership, emergency power plan monitoring, complaint for #2020016274, and a focused control survey was conducted on at Bearded Oaks Place, an assisted living facility in Sarasota, Florida. Complaint #2020016274 was substantiated at A 0025. The following deficiencies were identified at the time of survey.	A 000		
A 025 SS=I	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall 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 must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 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 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 and staff interview, the facility failed to properly supervise 1 (Resident #3) of 3 residents reviewed. Failure to provide adequate supervision and a secure environment for Resident #3 led to the resident's elopement on . While Resident #3 was unsupervised out of the facility, there was a high likelihood of serious injury, harm, or . The facility also	A 025		

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A 025	Continued From page 2 failed to provide supervision to all residents in the facility when the sole staff member left the facility. The findings included: Incident report review for Resident #3 found the following: On . . . . . , (time not provided) Staff D received a call from the facility next door (owned by the same company). Per the incident report Staff D left unattended all 4 residents and went to help staff in the facility next door. Resident #3 figured out the gate code and left the facility. The neighbor saw the resident and called the police. Per incident report on at about 4:00 p.m., law enforcement found the resident between two fences in the bushes couple blocks away from the facility. Resident #3 appeared intoxicated. Resident #3 had small cuts and . Law enforcement notified the facility of resident's elopement. Resident #3 was transferred to the hospital by law enforcement and returned to the facility around 9:00 p.m. At that time of return Resident #3 was still intoxicated. Resident #3 told Staff D Resident # 1 gave him two bottles of vodka. He proceeded to show the empty bottles to staff and went to sleep. Record review for Resident #3 found he was admitted to facility on . . . . . . Health assessment review for Resident #3 found diagnosis of . . . , , and resident was not at elopement risk. Further review found facility had a supervision rating scale tool utilized for all residents. Resident #3 was assessed on . Outcome of assessment indicated the following: "patient is under full-time indirect supervision. At least one supervising person is always present but does not check on patient more than once in 30 minutes."	A 025		

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A 025	Continued From page 3 Per assessment on record resident to be supervised every 30 minutes for A and B shift and every two hours for C shift. Record review found a form titled "client daily activity log." The log for Resident #3 was blank for the date of the elopement . Further review found client daily activity log was blank for all 4 residents. During an interview on at 1:03 p.m., Staff D said she received a phone call from the facility next door on at 3:15 p.m. Staff D said they told her they had 3 different issues and needed her help. Staff D admitted she left all 4 residents alone and went next door to help. Said around 4:00 p.m., police officers called her and told her Resident #3 was found near the facility and they will take him to the hospital for assessment. Staff D admitted she was unaware Resident #3 was gone. Staff D admitted she was supposed to check Resident #3 every 30 minutes, but she failed to do so. Staff D said she was supposed to document her observation at the log, but she failed to do so. Staff D said she never left residents unattended before. Staff D said it was a very unusual situation. They needed her help. On at 1:16 p.m., Resident #3 said Resident #1 was the one that gave him two bottles of vodka. Said he wanted to go out to get some beer. When he realized Staff D left the facility, he opened the gate door and took off. Said it was the first time he was left alone, and he did not want to miss the opportunity to get some beer. He said he memorized the code. He said he went to the store, but they did not sell him anything. He said he was coming home when the police found him and took him to the hospital. He said he did not remember how long he was out. He said the time in the ambulance and the	A 025		

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A 025	Continued From page 4 hospital was the longest. On at 1:50 p.m., the manager acknowledged Staff D did not follow facility's protocol. The Manager said Staff D should not have never left residents unsupervised. The Manager said Resident #3 never attempted to leave the premises before and was not deemed as at risk for elopement. The Manager said he conducted an investigation and found out Resident #1 had a cellular phone. Resident #1 called a friend to come and bring him some vodka. His friend came and threw plastic bottles of vodka over the fence for him to drink. He then proceeded to share the bottles with Resident #3. Resident #3 became drunk, but he wanted more . He realized Staff D left and opened the gate and left the facility. He could not pinpoint how long Staff D was not there since the client daily activity log was blank for all 4 residents. Failure to properly supervise Resident #3 led to his elopement on . Class II	A 025		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next	A 162		

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A 162	Continued From page 5 of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [illegible], or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. Records of residents receiving nursing services from a third party must contain all orders for nursing services, all nursing assessments, and all nursing progress notes for services provided by the third party nursing services provider. Facilities that do not have such documentation but that can demonstrate that they have made a good faith effort to obtain such documentation may not be cited for violating this paragraph. A documented request for such missing documentation made by the facility administrator within the previous 30 days will be considered a good faith effort. The documented request must include the name, title, and phone number of the person to whom the request was made and must be kept in the resident's file. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their [illegible] recorded	A 162		

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A 162	Continued From page 6 semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the of a	A 162		

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A 162	Continued From page 7 health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain a complete resident record for 1 (Resident #5) of 3 resident records reviewed. The findings included:	A 162		

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A 162	Continued From page 8 On . . . . . at 8:30 a.m., requested resident record for Resident #5. Requested record again at 10:00 a.m., 11:11 a.m., 1:10 p.m., and 1:41 p.m. On at 3:00 p.m., the facility Manager said that Resident #5's record was not on premises. The Manager said Resident #5 was admitted on . . . . . and discharged on . . . . . When Resident #5 was discharged from the facility, the resident's case manager took the resident's record with her. The Manager said he has been calling the resident's case manager all morning. The Manager said Resident #5's case manager could not locate the record. A last attempt to obtain the status of the record was made via email to the provider on at 4:22 p.m. The provider still did not have Resident #5's record. Class III	A 162		