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
	AL11953679	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF SARASOTA	7130 BENEVA ROAD SARASOTA, FL 34238

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A 000	Initial Comments An unannounced focused control, emergency power plan and complaint survey for #2020003797 & 2020015145 was conducted through at Savannah Grand of Sarasota, an assisted living facility in Sarasota, Florida. Complaint #2020003797 was substantiated at 0025 and 0032. Complaint #2020015145 was substantiated at 0025 and 0165. The following is description of the deficiencies.	A 000		
A 025	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.	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 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 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 staff interviews, the facility failed to have proper supervision to ensure a safe environment to meet the resident's needs for 2 (Residents #1 and #2) of 2 residents reviewed for adverse incidents. The facility failed to properly assess and monitor Resident #1 after moving in to prevent an	A 025		

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A 025	Continued From page 2 elopement in the middle of the night. Facility staff did not know she was missing until a family member called and reported that she was picked up and at the hospital. The facility failed to provide adequate supervision that lead to an alleged verbal and , , of Resident #2 by a night shift caregiver that caused the resident to be fearful and upset. Then the facility lacked investigation, documentation, and in-servicing of key staff which left other residents at risk for elopement or unidentified . . . . . The findings included: On review of the facilities intervention policy for at risk ˬ resident and elopement. Strategies to manage Elopement 1. Early identification and active monitoring can reduce the risk of a resident . . . ˬ away from the facility. 2. Priority one - is to identify at admission those who have a tendency to , to "elope." Keep in mind that most elopements occur within the first 48 hours. 3. Priority two - involves intervention to prevent elopement. Facility will encourage all staff to monitor the whereabouts of that , ... resident on a regular basis. 4. Knowing reason for residents . . . . . ˬ should be identified, such as irreversible . . . . . They are often looking for a family member. 5. Know elopement indicators. The profile of a resident likely to will include resident who are mobile and have a history of . . . . . ˬ. They may have a diagnosis which put them at risk such as . . . . . These individuals tend to disregard facility guidelines such as signing in or out of the facility.	A 025		

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A 025	Continued From page 3 1. On record review of Resident #1's medical record, it indicated that she was admitted to the facility on [redacted] with a diagnosis of [redacted]. She was documented as being oriented to herself and family only. She was also documented as having a [redacted] on admission and a risk. Resident #1 admitting documentation (1823) had marked that she was not an elopement risk and was independent in walking, [redacted] and using the bathroom. On review of Resident #1's observation log: showed that within 7 days of admission date of [redacted] she was documented as [redacted] the halls at night looking for her husband (who was [redacted]) staff reported [redacted] behaviors each night and it was documented in the notes. Resident was exit seeking as documented and then on [redacted] eloped without anyone knowing she was gone until Resident #1 daughter called the facility and reported to them that her mother had been picked up alongside the road and brought to the hospital. Resident #1 was returned to the facility and then tried again to elope on [redacted] with a group of other family members but was seen and brought [redacted] into the facility and was very agitated. Review of Resident #1's Elopement Incident Report dated [redacted] documented the resident was very [redacted] and her memory [redacted] had an influence in her decision to exit the facility. It was documented that due to resident's [redacted] state of mind she did not sign out or tell anyone she was leaving. Staff said they were not at the front of the facility where doors were located during the time of the incident. On [redacted] at 11:22 a.m., in interview with Executive Director (ED) she said that there was	A 025		

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A 025	Continued From page 4 no documentation of staff interviews or staff training in relation to this elopement incident or evidence of any elopement drills being done at that time. The ED said she would do the training now. 2. Resident #2's record review showed that she has diagnosis of , history of and and . She needs with transfers and personal care. Resident observation log recorded that on at 2:00 p.m., Wellness Director reported to ED the details of the alleged incident that had happen earlier that morning. On review of Facilities and Neglect Policy it defined as any willful act or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant , to adult's physical, mental, or emotional health. includes acts and omissions. - an unprivileged & intentional toughing of a resident in a harmful way. Such as slapping, pushing, tugging, punching, kicking etc, - any of the following verbalizations to or in the presence of a resident or visitors : Threatening words, words of coercion, words of extortion, words of vulgarity, and derogatory comments. Procedure: 1. Any person witnessing or otherwise becoming informed of any or neglect shall immediately report such to the Executive Director. The Executive Director shall obtain a written incident report from the individual making the claim of or neglect. In the event the individual making the claim is not an employee, the Executive Director shall complete the report.	A 025		

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A 025	Continued From page 5 2. The Director shall make a complete report of the incident and the corrective action taken. If . . . . . or neglect is deemed possible or confirmed a report must be filed with the Department for Children and Families (DCF). . . . . . by Staff: 1. In the event that an employee of the facility is accused of . . . . . , said employee shall be immediately suspended until a full investigation of the charges can be conducted. Training: 1. In addition to the review of the staffing employee handbook sections, on standards of conduct policy, all employees will be trained on recognizing physical or . . . . . at new hire orientation and annually thereafter. 2. All employees will be trained in reporting any alleged incident of physical or . . . . . at new hire orientation. This training will include reporting to Executive Director an alleged or suspected physical or . . . . . of a resident immediately upon suspicion. On . . . . . at 9:50 a.m., in interview with the ED, she said that she was the acting ED at the time of the incident and said she believes she found out about the alleged . . . . . incident about 24 hours after the first staff member was told of the issue on . . . . . She said that she talked with the staff member who had been told of the incident by the resident and asked them to write down what happened. The ED said she did not interview the caregiver Staff C (alleged abuser) because she was told by the risk manager to just wait for Department of Children and Families (DCF) to get there and talk to her. She had only interviewed the staff that had been talking about the incident in the meeting. She said by the time she found out about it, it was a day or two after it happened and when she went to talk with the	A 025		

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A 025	Continued From page 6	A 025		

resident, she did not talk about it. The ED said she was new to the job role and did not know what to do. She thought the DCF person was going to do an investigation. She said she did not know that she was to do a full investigation for her facility too. The ED said she terminated caregiver Staff C, after the incident because of other allegations of talking rough to residents & other items that she had been written up about in the recent past and now this incident. She said she did not know the outcome of the investigation, but she had heard enough from the staff. The ED said that she did not train all staff again on resident and neglect after this incident, but she would do it now.

On at 11:58 a.m., in interview with the Risk Manager, she said that she first learned about the alleged . . . . . incident on . . . . . when she received a call from the Executive Director (ED). She said that she told the ED that she should investigate the incident and speak with all the people involved then and write it up and send it to her and do the reporting to the state for the alleged . . . . . She said that what she was told is Resident #2 had said that a night shift staff member who was wearing a turquoise jacket or shirt had hit her on the side of the , grabbed her arm and yelled at her. She was told by ED that the resident had told 2 of the staff members what had happened but that she had not heard about it until today . The incident was supposed to have happened in the early morning hours of , after midnight. She said that the ED was told to call DCF and report the incident. The Risk Manager said that she was the one who put in the report.

On at 2:21 p.m., in interview with Med tech Staff A, she said she remembers the incident

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A 025	Continued From page 7 and she recalled that approximately at 7:30 a.m. on she went into Resident #2's room to provide her with breakfast. When she began speaking with the resident, she noticed the resident was rubbing the side of her . When she asked her what was wrong she said that someone had hit her in the . . . and grabbed her arm and hollered at her. She said she then asked the resident when it had happened, the resident said it was earlier that morning, but it was still dark out. Then she said she asked Resident #2 if she knew who it was, and the resident said she knew it was a woman and that she was wearing a turquoise shirt. Staff A said she then took care of the resident and went down and told the Wellness Director. She said after that she did not know what the Wellness Director did. She said later she then talked about it with Med tech Staff B about it at the change of shift. She said that she was aware of a night shift caregiver that always wore a turquoise hoodie while she was working. On at 2:55 a.m., in interview with Med tech Staff B, she said that she had come to the resident's room on afternoon shift on . The resident looked very frightened when she came into the room. She asked her what was wrong, and she said that something had happened to her in the night, around or after midnight. Staff did not want to make the resident more upset, so she did not press her anymore about it. She said that she had received . . . . . and neglect training. She said that she did not tell anybody else about the incident until another co-worker had asked her if Resident #2 had said anything to her. She said yes that she said something had happened to her. Staff said that after she heard what the other med tech told her she went and told the ED that afternoon. She	A 025		

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A 025	Continued From page 8 said she told her a little before 4:00 p.m., because she had just spoken with Med tech Staff A about the incident at the change of shift. Class III	A 025		
A 032	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of	A 032		

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A 032	Continued From page 9 at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(i), F.S. This Statute or Rule is not met as evidenced by: Based on record review, and staff interviews, the facility failed to ensure a safe environment to meet the resident's needs for 1 (Resident #1) of 2 residents reviewed for adverse incidents. The facility failed to properly assess and monitor Resident #1 after moving in to prevent an	A 032		

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A 032	Continued From page 10	A 032		

elopement in the middle of the night. Facility staff did not know she was missing until a family member called and reported that she was picked up and at the hospital.

The findings included:

On Review of the facilities intervention policy for at risk resident and elopement.
Strategies to manage Elopement
1. Early identification and active monitoring can reduce the risk of a resident away from the facility.
2. Priority one - is to identify at admission those who have a tendency to , to "elope." Keep in mind that most elopements occur within the first 48 hours.
3. Priority two - involves intervention to prevent elopement. Facility will encourage all staff to monitor the whereabouts of that resident on a regular basis.
4. Knowing reason for residents should be identified, such as irreversible . They are often looking for a family member.
5. Know elopement indicators. The profile of a resident likely to will include resident who are mobile and have a history of . They may have a diagnosis which put them at risk such as . These individuals tend to disregard facility guidelines such as signing in or out of the facility.

On record review of Resident #1's medical record, it indicated that she was admitted to the facility on with a diagnosis of . She was documented as being oriented to herself and family only. She was also documented as having a on admission and a risk. Resident #1's admitting documentation

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A 032	Continued From page 11 (1823) had marked that she was not an elopement risk and was independent in walking, [illegible] and using the bathroom. On review of Resident #1's observation log: showed that within 7 days of admission date of [illegible] she was documented as [illegible] the halls at night looking for her husband (who was [illegible]) staff reported [illegible] behaviors each night and it was documented in the notes. Resident #1 was exit seeking as documented and then on eloped without anyone knowing she was gone until Resident #1's daughter called the facility and reported to them that her mother had been picked up alongside the road and brought to the hospital. The resident was returned to the facility and then tried again to elope on with a group of other family members but was seen and brought [illegible] into the facility and was very agitated. Review of Resident #1's Elopement Incident Report dated [illegible] documented the resident was very [illegible] & her memory , had an influence in her decision to exit the facility. It was documented that due to resident's [illegible] state of mind she did not sign out or tell anyone she was leaving. Staff stated they were not at the front of the facility where doors were located during the time of the incident. On at 11:22 a.m., in interview with Executive Director (ED), she said that there was no documentation of staff interviews or staff training in relation to this elopement incident or evidence of each elopement drills being done at that time. The ED said she would do the training now. Class III	A 032		

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A 165	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: 1. ; 2. or , damage; 3. Permanent ; 4. or 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	A 165		

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SAVANNAH GRAND OF SARASOTA	7130 BENEVA ROAD SARASOTA, FL 34238

(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 165	Continued From page 13 incident, through the agency's online portal, or if the portal is offline, by electronic 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, through the agency's online portal, or if the portal is offline, by electronic 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) . , neglect, or . , . 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 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	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953679	A. BUILDING: _____ B. WING _____	10/07/2020

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A 165	Continued From page 14 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), 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 staff interviews, the facility failed to a complete a 15-day adverse incident report with the state on an alleged allegation for 1 (Resident #2) on 2 adverse incidents reviewed. The findings included: Resident #2's record review showed that she has diagnosis of , history of and , and . She needs	A 165		

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A 165	Continued From page 15 . . . . . with transfers and personal care. Resident observation log recorded that on . . . . . at 2:00 p.m., Wellness Director reported to ED the details of the alleged incident that had happen earlier that morning. On . . . . . at 9:50 a.m., in interview with the Executive Director (ED) she said that she was the acting ED at the time of the incident and said she believes she found out about the alleged incident about 24 hours after the first staff member was told of the issue on . The ED said she was new to the job role and did not know what to do. She thought the DCF person was going to do the investigation. She said that she sent information to the Risk Manager that she got on the alleged . . . allegations she was told about by the staff that Resident #2 had talked to. She said the Risk manager was going to prepare and send in the report to the state. On at 11:58 a.m., in interview with Risk Manager she said that she first learned about the alleged . . incident on when she received a call from the ED. She said that she told the ED that she should investigate the incident, and speak with all the people involved, then write it up and send it to her and she would write up and do the reporting to the state for the alleged . The Risk Manager said that she was the one who put in the report and then withdrew it by accident. She said that she was not from the state of Florida and she was not familiar with the reporting and accidently withdrew that report and did not know how to get it . . . in. The report history shows that Risk Manager submitted the report on . . . . . at 6:51 p.m., and withdrew it on at 5:32 p.m., after the agency requested additional information. The Risk Manager said that she then just wrote it out	A 165		

Agency for Health Care Administration

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A 165	Continued From page 16 on an Agency for Health Care Administration (AHCA) adverse incident information form but did not re-submit it. Class III	A 165		