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
	AL11964477	A. BUILDING: _____ B. WING _____	R 10/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PORT CHARLOTTE	18440 TOLEDO BLADE BLVD PORT CHARLOTTE, FL 33952

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{A 000}	Initial Comments An unannounced revisit survey was conducted in conjunction with a focused control and complaint survey for complaint #2019016585 on at Brookdale Port Charlotte, an assisted living facility in Port Charlotte, Florida. This was a follow-up to the complaint survey completed on . The following is description of the deficiencies found at the time of the visit.	{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.	{A 025}		

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{A 025}	Continued From page 1 (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 interview, the facility failed to notify family/power of attorney of significant changes and other changes that resulted in the provision of additional services for 1 (Resident #1) of 3 residents reviewed for family notification. The findings included: A review on of Resident #1's progress notes revealed the following: Progress notes dated ..... indicated Resident #1 was kicking at staff, had increased agitation and aggressive behaviors. Notations were faxed to , Nurse Practitioner and Primary	{A 025}		

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{A 025}	Continued From page 2 Nurse Practitioner (NP) to give update. There was no documentation that family/power of attorney (POA) were notified. Progress note dated . . . . . indicated Resident #1 was seen by , Nurse Practitioner who ordered a . , . . to rule out . . , . . . ( ). There was no documentation that the family/POA was notified. Progress notes following this order indicated the following: " Resident #1 refused to give sample, ... trying to get Home Health to straight cath, no specimen collected on this shift, ... Home Health (HH) to straight cath, no specimen this shift resident is . , ... HH unable to obtain sample due to behaviors, NP notified. staff continue to place on toilet no specimen collected, . Seen by HH to straight cath, but unsuccessful. . . . . HH in to collect UA C&S via straight cath, but was unable to get any . . . . . New order from NP for . . . . . for ." None of these notes that the family/POA had been notified of difficulty in obtaining specimen. A handwritten note from the Administrator was found in the chart dated . . . at 10:36 a.m. The letter indicated she had spoke with Resident #1's son to inform him Resident #1's care needs had increased due to requiring two person assist and increased behaviors. Son acknowledged. Note then indicated at approximately 11:03 a.m., Resident #1's daughter called and asked if her mother had been tested for a . The Administrator told her they had received an order and after multiple failed attempts they were seeking an order for straight . . . . . There were no further notes in the chart from the	{A 025}		

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{A 025}	Continued From page 3 Administrator that the family/POA had been kept up with any further success/failure of obtaining the specimen or the ordering of [redacted]. Progress note on [redacted] at 1:38 p.m. indicated Resident #1 had been sent out to the hospital at 3 a.m. that morning for [redacted] and [redacted]. There was no documentation that family/POA was notified about the decline in condition and transfer. Progress note on [redacted] at 3:31 p.m. indicated a call was placed to the hospital regarding the status of Resident #1 and were told she had been admitted to the [redacted] with a diagnosis of [redacted] and [redacted]. Family/POA and physician were notified at this time. On [redacted] at 11:46 a.m., the Director of Nursing (DON) agreed there was no documentation the family was kept up to date with the changes in behavior, new orders or difficulty and delay in obtaining a specimen and treatment. The DON agreed documentation showed a 12 hour delay from the time the resident was sent out to the hospital with a change in condition and the family was notified, and by the time the family was notified, Resident #1 had been admitted to the with [redacted] and [redacted]. Class III	{A 025}		
{A 030}	59A-36.007(6) FAC; 429.28([redacted]) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY	{A 030}		

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{A 030}	Continued From page 4 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 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. . . . . and tobacco use; 3. Medication storage; 4. Resident elopement;	{A 030}		

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{A 030}	Continued From page 5 5. Reporting resident . . . . . , neglect, and , ; 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 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	{A 030}		

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{A 030}	Continued From page 6	{A 030}		

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.
(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

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{A 030}	Continued From page 7 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 . . . . . for health care services, the provision of or arrangement of transportation to health care . . , 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 , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for 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	{A 030}		

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{A 030}	Continued From page 8 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, [illegible], 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 [illegible] Hotline operated by the Department of Children and Families, and, if applicable, [illegible], 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 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	{A 030}		

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{A 030}	Continued From page 9 possible, unless the resident is adjudicated , or , 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: Based on record review and interview, the facility failed to honor the residents rights for independent personal decisions and failed to assist with obtaining adequate and appropriate healthcare consistent with established and recognized standards within the community for 1 (Resident #1) of 3 residents reviewed. The findings included: A review of Resident #1's chart on revealed she had been sent out to Hospital A on and admitted to the with a ( ), and . Resident #1's Resident Information and Emergency Contact sheet indicated she preferred to be sent to Hospital B. On at 11:32 a.m., the Director of Nursing (DON) said if the resident is alert they will ask them what hospital they want to go to and if they are unable to indicate, they will ask the family/ Power of Attorney (POA.) The DON said if	{A 030}		

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the transferring staff member didn't call the POA then it would have been up to the paramedics based on her symptoms. The DON said she was not aware of a form in the file that indicated Resident #1 preferred to be sent to Hospital B. The DON agreed there was no documentation the family had been notified Resident #1 was being transferred, the paramedics had been informed of her hospital choice and this information was not documented on the sheet or other materials sent with Resident #1 to the hospital.

A progress note dated indicated Resident #1 was kicking at staff, had increased agitation and aggressive behaviors. New orders were received on for a (UA).

Progress notes following this order indicated the following: " Resident #1 refused to give sample, trying to get Home Health to straight cath, no specimen collected on this shift, Home Health (HH) to straight cath, no specimen this shift resident is HH unable to obtain sample due to behaviors, NP notified. staff continue to place on toilet no specimen collected, Seen by HH to straight cath, but unsuccessful. HH in to collect UA C&S via straight cath, but was unable to get any New order from NP for for ."

Progress note on at 1:38 p.m. indicated Resident #1 had been sent out to the hospital at 3 a.m. that morning for and . Progress note on at 3:31 p.m. indicated a call was placed to the hospital regarding the status of Resident #1 and were told she had been admitted to the with a

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{A 030}	Continued From page 11 diagnosis of . , ... and . . . . . . Progress note on indicated Resident #1 had expired at the hospital. On . . . . . at 11:46 a.m., the DON said Resident #1 was always alert with , but the . . . . increased so they requested a U/A. She said Resident #1 started to get combative when they tried to get a sample, Home Health couldn't get a sample due to behaviors and said even when they could get the . . . . . in, they still couldn't get , just a thin -like substance is what they told her. At 12:30 p.m., the DON said no concern was raised when no one was able to obtain the specimen for 8 days because behaviors for Resident #1 were not abnormal for her. On . . . . . at 11:52 a.m., an Executive Director from a sister facility arrived. She said she came to offer assistance with the survey as the facility's Administrator was out on leave. On at 12:41 p.m., the Executive Director from a sister facility said the process should be if they can't get the sample in 48 hours, an order for a straight . . . . . should be obtained. If still unable to obtain a sample, the resident should be sent out. The visiting Executive Director said she is not sure what happened, but maybe because of the pandemic, they didn't send her out. Class II	{A 030}		