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
	AL11963949	A. BUILDING: _____ B. WING _____	10/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE BRADENTON GARDENS	5612 26TH STREET WEST BRADENTON, FL 34207

(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 Investigation (Complaint Number: 2020017452), a Generator Monitoring, an Control Visit, and a Limited Nursing Services Monitoring Visit were conducted at Brookdale Bradenton Garden on . Deficiencies were identified at the time of survey.	A 000		
A 025 SS=G	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 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 025		

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A 025	Continued From page 1 (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 interview, the facility failed to maintain an awareness of Memory Care residents' health and safety and provide those residents with oversight when they out of the facility into the Memory Care courtyard placing the residents at risk for sun exposure, heat exhaustion, and . Furthermore, the facility failed to provide care and services to meet the needs for for one Resident (#1) of one sampled resident that had frequent . Findings Included:	A 025		

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A 025	Continued From page 2 During observations of the Memory Care Unit's courtyard, conducted on at 11:20am, the courtyard was located off the dining room of the unit. The door was observed unlocked and residents could come and go on their own. There were no alarms or alerts to notify staff that a resident had opened the doors and went out into the courtyard. There was a covered screened-in room and the courtyard was observed to be in full sun with sitting areas (tables and chairs) but no shade. There were no drink stations or video cameras to view the entire courtyard area. Resident #1 was observed to be seated on a high metal chair with cushions in the sun. Resident #1 was wearing a long sleeve sweater, capri pants, and socks but no shoes. Resident #1 had multiple dry scabbed areas to her right upper forehead, a right black , and purpled colored to the left side of her . . . Resident #1 appeared and slow to respond. At 11:29am, Staff A came out to the courtyard and offered Resident #1 a small cup of water and the resident was slow to respond. Staff A attempted to return into the Memory Care but was unable as the double doors were both locked. Staff A knocked on the door and looked through the two small windows. Staff A finally pulled out her phone to call another staff to assist her inside. Staff A propped the door open but left Resident #1 outside. At 11:46am, Resident #1 continued sitting in the sun. During an interview with Staff A, conducted on at 11:29am, Staff A stated that all the staff should have a key to open the doors to the courtyard. Staff A stated that the courtyard doors were opened to go out but locked to come . . . . inside and that was the reason that the staff propped the door open. Staff A stated that we lock the doors at night.	A 025		

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A 025	Continued From page 3 An observation on beginning at 02:00pm, revealed Resident #1 continued to have no shoes on her and one sock on right and one sock halfway off on her left . . . The socks appeared to be nylon socks and did not have slip protection. The courtyard double doors were both unlocked to go outside; the left door was unlocked and the right door was locked to come inside. The courtyard area continued to be in full sun. One unidentified staff looked through the two small windows of the double doors to check on residents in the courtyard. The entire courtyard was not visible from these two small windows. At 02:19pm, Resident #1 continued without appropriate footwear. At no time did any staff attempt to assist Resident #1 with appropriate footwear. A record review for Resident #1, conducted on . . . . . , revealed that Resident #1 had . . on at 11:36am with a injury and was not sent to the hospital for evaluation. At 06:08pm, Resident #1 was sent to the hospital for evaluation and treatment of sun exposure, possible heat exhaustion, and elevated temperature of 103 degrees after being found unresponsive outside in the Memory Care courtyard. Resident #1 had documented . . on , , , , and . . . . . . During an attempt to review the in-house incident reports for both Resident #1's incidents on . . . . . , conducted on . . . . . , there were no in-house incident reports to review for both Resident #1's incident that occurred on . There were no intervention/prevention measures described on any of the incident reports for Resident #1.	A 025		

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A 025	Continued From page 4 Resident #1's Health Assessment Form dated stated that the resident's Physical/Sensory Limitation was wheelchair level. Resident #1 was also prescribed and taking the medication 0.5mg three times by three times every day, which increased the resident's risk. A review of the Facility's Policy and Procedures, conducted on , revealed that the Facility was supposed to complete an in-house incident report with every that included interventions put in place "to reduce the potential for future and injury. A review of the Incident Reporting Policy and Procedures revised , conducted on , revealed that the Facility was supposed to document incidents "in the Client Record and on the progress note on the same day of the occurrence with basic data and details go on the Incident Report". A review of the Injury Policy and Procedures revised , conducted on , revealed that the Facility was to send "all residents sustaining injury to receive immediate attention for serious injury". During an interview with the Health and Wellness Director (HWD), conducted on at 04:15pm, the HWD stated that the staff know to look outside to check on residents and that there were no documented wellness checks for residents in and out of the Memory Care courtyard. The HWD agreed that Facility did not follow their Incident Reporting Policy and Procedures. During the Exit Conference with the District	A 025		

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A 025	Continued From page 5 Director of Clinical Services, Regional Director and Registered Nurse Case Manager, and the HWD, conducted on . . . . . at 05:24pm, all agreed that there was no check system for the Memory Care courtyard and agreed that there was no alarm/alert to notify staff of residents that come and go into the courtyard on their own. All agreed that that a better system needed to be in place for the safety and wellbeing of the Memory Care residents. Jennifer stated that staff on day shift must have forgotten to unlock the doors this morning; agreed that Jean's family needs to be notified of proper fitting shoes The HWD stated that the day shift staff must have forgotten to unlock the doors this morning. All agreed that Resident #1's family needs to be notified that the resident needs proper fitting shoes. Class II	A 025		
A 165 SS=D	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 165		

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A 165	Continued From page 6 (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 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	A 165		

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A 165	Continued From page 7 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 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	A 165		

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A 165	Continued From page 8 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 observations, record review, and interview, the Facility failed to submit a one day and fifteen Adverse Incident Report notifying the Agency that one Resident (#1) had an event over which the Facility personnel could exercise control when Resident #1 was sent to the hospital for heat exhaustion. Findings Included: During observations, conducted on at 11:20am, the Memory Care patio door was unlocked where residents could come and go on their own into the courtyard area. There was no alarm/alert to inform staff that a resident went out into the patio area. There were no shaded areas in the full sun patio area. At 11:29am, Resident #1 was observed to be locked out of the building as the doors were unlocked to come out but locked to go into the building. At approximately 02:10pm, staff were observed looking through two small windows of the double doors leading to the Memory Care courtyard. The entire courtyard was unobservable through the two small windows. Staff were not observed at any time observing the entire courtyard where Memory Care residents may out to. A record review for Resident #1, conducted on	A 165		

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A 165	Continued From page 9 . . . . . , revealed that Resident #1 was sent to the hospital on for unresponsiveness, a temperature of 103 degrees, and staff applied ice to the resident to bring down the elevated temperature after Resident was found in the Memory Care courtyard. During an attempt to review Resident #1's one day and fifteen-day Adverse Incident Report, conducted on . . . . . , there was none provided to review. During an interview with the Health and Wellness Director, conducted on . . . . . at 03:30pm, the Health and Wellness Director agreed that no Adverse Incident Report had been submitted for Resident #1 for the event that took place on . . . . . . Class III	A 165		