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
	AL11969329	A. BUILDING: _____ B. WING _____	01/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIANA OF VENICE	2321 E VENICE AVE VENICE, FL 34292

(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 An unannounced complaint survey for #2020017587 was conducted on [redacted] at Liana of Venice, an assisted living facility in Venice, Florida. Complaint #2020017587 was substantiated at A025, A165 and Z821. The following is description of the deficiencies.	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 [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 [redacted] 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.	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 (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, staff interview, and review of hospital and Emergency Medical Services (..) records, the facility failed to provide adequate supervision for 1 (Resident #1) of 2 resident records reviewed and failed 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.	A 025		

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A 025	Continued From page 2 The facility also failed to properly supervise 1 (Resident #2) out of 2 resident records reviewed. Failure to provide adequate supervision and a secure environment for Resident #2 led to resident's elopement on . While Resident #2 was unsupervised out of the facility, there was a high likelihood of serious injury, harm, or . The findings included: 1. Record review for Resident #1 found the following note dated at unknown time: "resident was brought from courtyard in the afternoon and was convulsing on and off." Resident was sent to the hospital where he was admitted due to acute heat . The record did not specify time of day, how long resident was left out or who the staff member was that let him out. Furthermore, there was no written record of which staff found him and brought him in. . record review provided by the facility found the following note dated : " , likely secondary to heal exhaustion/.....Possible , / resulting in ." Hospital notes dated indicated "patient was found outside for unknown time. He was shaking and had temperature of 105.7 F when arrived. identified ." Per note on record when Resident #1 arrived at ER temperature was 103.1F and later 102 (after initial ice pack treatment). Resident #1 had . Chief complaint listed: heat . Resident was identified as being and nonverbal. In an interview with the assisted living facility Administrator on at 9:30 a.m., she said	A 025		

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A 025	Continued From page 3 she was off the week of . . ¸ . . . She remembered the previous Administrator mentioned to her the issue when she returned, but she did not have the specifics. She said she though the incident took place sometime between first and second shift. First shift is 6 a.m. to 2 p.m. and the second shift is 2 p.m. to 10 p.m. In an interview with the assisted living facility Director of Nursing (DON) on at 10:10 a.m., she said she started in . . . . . and was not present at the time of the incident. Said she did not have specifics regarding the event. She did not have a timeline nor investigation. Furthermore, she was not aware of which staff was involved. During an interview on at 10:42 am., Staff A, Caregiver, said she worked the second shift the day of the incident. She said, "I wasn't here when it happened, but I heard he was sitting out for an hour or so. He was ¸ mostly. He had sun . . . I was not here when that happened." Staff B, Caregiver, according to the schedule was working on the first shift the day of the incident. She said on at 10:52 .a.m., she did not remember anything. She remembers he was in the hospital. She did not remember any additional training. Staff C, Caregiver, worked on the first shift at the time of the survey. He said on at 11:18 a.m., he does not recall anything. He did not remember the incident or any training. Staff D, Licensed Practical Nurse (LPN) on at 12:31 p.m., said, "I was not here but heard he was out for a very long time. By the	A 025		

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A 025	Continued From page 4 time they found him he had . . . . . and high temperature. No, I did not receive additional training after the fact." Staff E, Caregiver, working on the second shift the day of the incident said on at 12:46 p.m., "I don't recall anything. I don't remember anything". Staff F, Caregiver, was working on the second shift the day of the incident. Said on . . . . . at 1:00 p.m., "I recall nothing. No, I don't remember anything of that day." Staff G, LPN said on . . . . . at 1:09 p.m., She was the one that found the resident. He was in the courtyard. It was about 2:30 p.m. to 3 :00 p.m., She asked two caregivers to help her bring him in, Staff F and Staff H. Staff G said it was in the beginning of her shift. She has no idea who left the resident out in the courtyard nor how long he was there. She said the resident's skin was warm to the touch. He was shaking. He was wet. His whole body was wet and felt very warm. He did not respond to external stimuli. She immediately called 911. She did not have specifics to share related to residents' vitals or temperature. The facility policy regarding monitoring residents while sitting in the courtyard was requested. The Administrator said on at 12:11 p.m., they had none. She said she just had an outdoor activity policy and procedure. 2. On at 9:00 p.m., Staff D, LPN, saw Resident #2 walking down the hallway. At 9:30 p.m., Staff D was passing medications to Resident #3 (Resident #2's brother in law.) Resident #3 told her Resident #2 is out. Resident	A 025		

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A	Continued From page 5 #3 said Resident #2 deactivated the window alarm, removed the screen, and left the building. Staff D, LPN, observed a hole on the window screen. She immediately started looking for the resident. On at 9:40 p.m., the doorbell rang, and the police were there with Resident #2. They told her someone saw the resident and they called the police. The police found him at the facility's rear parking lot and brought him . During an interview on at 9:31 p.m., Staff D, LPN, said she was passing medications to Resident #3 and Resident #3 said Resident #2, his brother in law, was gone. He left the building. Staff D initially did not believe him, but then saw the hole in the window screen and realized that it must be true. Staff D immediately called the maintenance director, but he was gone. She began looking for the resident and as she was getting ready to call the Administrator the doorbell rang, and a police officer was there with resident #2. The officer told her someone saw the resident and they called them. The Administrator said on at 12:56 p.m., Resident #2 had a military background. They believe he was able to deactivate the window guard and his brother in law (Resident #3) helped him. She said the last time they saw the resident was 9:00 p.m. She said, she later saw the video of the -parking lot which showed the resident being there around 9:17 p.m. She said they do not have a specific policy that speaks as to how often they monitor residents. She said the standard of practice is every 2 hours since that is a memory unit. Class II	A 025		

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A 165	Continued From page 6	A 165		
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) 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	A 165		

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A 165	Continued From page 7 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 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	A 165		

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A 165	Continued From page 8 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 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 reviewed and staff interview facility failed to submit Adverse Incident Reports to the Agency within 1 business day after the occurrence of the incident, and within 15 days after the occurrence of the incident as required in section 429.23, F.S. The findings included:	A 165		

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A 165	Continued From page 9 Record review for Resident #1 found the following note dated at unknown time: "resident was brought from courtyard in the afternoon and was convulsing on and off." Resident was sent out to the hospital where he was admitted due to acute heat . The record did not specify time of day, how long resident was left out or who was the staff member that let him out. Furthermore, there was no written record of what staff found him and brought him in. Hospital record review for Resident #1 found resident was admitted to the the hospital on with, " , likely secondary to heat exhaustion/.....Possible / resulting in ." In an interview with the Assisted Living Facility Administrator on at 9:30 a.m., she said she was off the week of . She remembered the previous Administrator mentioned to her the issue when she returned, but she did not have the specifics. She said she though the incident took place sometime between first and second shift. First shift is 6 a.m. to 2 p.m. and the second shift is 2 p.m. to 10 p.m. Hospital notes for Resident #1 dated : "patient was found outside for unknown time. He was shaking and had a temperature of 105.7 F when arrived. identified ." Per note on record when resident #1 arrived at ER temperature was 103.1F and later 102 (after initial ice pack treatment.) Resident#1 had . Chief complaint listed: heat . Resident was identified as being and non-verbal. When an adverse incident regarding	A 165		

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A 165	Continued From page 10 Resident#1's heat episode was requested, the Administrator said on at 10:30 a.m., the previous administrator left the facility the end of , and she did not leave any documentation behind. The administrator said she did not believe the previous administrator filled an adverse incident, but she was not sure. A phone call to the Agency for Health Care Administration Field Office took place on at 10:37 a.m., and requested adverse incident related to Resident #1. A phone call received from the Field Office Supervisor on at 10:49 a.m., confirmed the lack of an adverse incident. Class III	A 165		

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CZ821 SS=D	59A-35.110 FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under chapter 408, part II, F.S., or authorizing statutes for the provider type as specified in section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections; and, (f) Approval of revisions to emergency management plans. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and availiable at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On	CZ821		

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CZ821	Continued From page 1 Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 2. Assisted living facilities: a. Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 days after the occurrence of the incident as required in section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and availiable at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. b. Liability claim reports required pursuant to section 429.23(5), F.S., and rule 58A-5.0242, F.A.C. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and availiable at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted	CZ821		

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CZ821	Continued From page 2 electronically to the Agency within 15 calendar days after the occurrence of the incident as required in section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and availiable at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record reviewed and staff interview facility failed to submit Adverse Incident Reports electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 days after the occurrence of the incident as required in section 429.23, F.S. The findings included: Record review for Resident #1 found the following note dated . . . . . at unknown time, "resident was brought from courtyard in the afternoon and was convulsing on and off." Resident was sent to the hospital where he was admitted due to acute heat . . . . . The record did not specify time of day, how long resident was left out or who the staff	CZ821		

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
	AL11969329	A. BUILDING: _____ B. WING _____	01/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIANA OF VENICE	2321 E VENICE AVE VENICE, FL 34292

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CZ821	Continued From page 3 member was that let him out. There was no written record of what staff found him and brought him in. Hospital record review for Resident #1 found the resident was admitted to the hospital on with, " . . . . Likely secondary to heat exhaustion/ .....Possible , / resulting in . . . ." Per hospital for Resident #1 notes dated . . . . "patient was found outside for unknown time. He was shaking and had temperature of 105.7 F when Emergency Medical Services ( ) arrived. identified . . . . . "Per note on record when resident #1 arrived at Emergency Room (ER) temperature was 103.1F and later 102 (after initial ice pack treatment.) Resident#1 had . . . . . Chief complaint listed: heat . Resident was identified as being . . . . and non-verbal. In an interview with the Assisted Living Facility Administrator on at 9:30 a.m., she said she was off the week of . . . . She remembered the previous Administrator mentioned to her the issue when she returned, but she did not have the specifics. She said she though the incident took place sometime between first and second shift. First shift is 6 a.m. to 2 p.m. and second shift is 2 p.m. to 10 p.m. When an Adverse Incident Report regarding Resident#1's heat episode was requested, the Administrator said on . . . . . at 10:30 a.m., the previous Administrator left the facility the end of . . . and she did not leave any documentation behind. The Administrator said she did not believe the previous Administrator filled an Adverse Incident Report, but she was not sure.	CZ821		

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
	AL11969329	A. BUILDING: _____ B. WING _____	01/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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CZ821	Continued From page 4 A phone call to the Agency for Health Care Administration Field Office took place on . . . . at 10:37 a.m. and requested Adverse Incident Report related to Resident #1. A phone call received from the Field Office Supervisor on . . . . at 10:49 a.m., confirmed the lack of an Adverse Incident Report. Class III	CZ821		