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
	AL11932376	A. BUILDING: _____ B. WING _____	04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLARIS SENIOR LIVING NORTH NAPLES	10949 PARNU STREET NAPLES, FL 34109

(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 focused control and complaint survey for #2021000156 was conducted on at Solaris Senior Living North Naples, an assisted living facility in Naples, Florida. Complaint #2021000156 was substantiated at A025. The following is description of the deficiency.	A 000		
A 025 SS=D	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	A 025		

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A 025	Continued From page 1 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 interview, the facility failed to assess residents for significant changes in condition and failed to contact resident's legal representative with significant medication changes for 1 (Resident #1) of 3 residents reviewed for significant changes and quality of care. The findings included:	A 025		

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A 025	Continued From page 2 On at 11:14 a.m., in an interview, Resident #1's daughter said she visited her mother on and , Resident #1's daughter said her mother was completely incoherent and "really doped up." The daughter said Resident #1 was black and blue on her arms, from all the way up and was in a wheelchair, which was not normal because her mother could walk. She said her mother was taken to the hospital on the 13th to have surgery for a , . Record review revealed Resident #1 was admitted to the facility on . Resident #1's Health Assessment Form 1823 (1823) dated indicated Resident #1's only medication was (medication for lowering). The 1823 also indicated she had a recent and required supervision with ambulation due to unsteady gait. A letter of lacks capacity was in the record signed on , and the daughter had been appointed Health Care Proxy (HCP) with responsibility of making health care decisions on . Progress notes throughout stay indicated resident able to walk independently and frequently throughout the facility and on occasion into other resident rooms. Record review revealed a prescription order on for , 25 mg at bedtime. The area under diagnosis for medication was left blank. , is an , , drug with side effects including . This order was increased on to , 25 mg oral twice a day at 9:00 a.m. and 5:00 p.m. The area indicating diagnosis for medication was blank. The medication administration record indicated a diagnosis of unspecified without behavioral disturbance and a physician's	A 025		

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A 025	Continued From page 3	A 025		

progress note dated read: The patient is no longer going to other individuals' rooms and taking any items. I will continue with a low dose of at night. Per progress notes, an order was received on at 3:08 p.m., to decrease from 25 mg twice a day to 12.5 mg twice a day. No documentation was found in the chart that the HCP had been informed of Resident #1 starting on or that the dose had been increased on and decreased on .

On at 1:40 pm., the Director of Nursing (DON) said a person being started on an medication should have increased monitoring. DON said she personally checks after a week or so that the person is not . The DON agreed there was no documentation that anyone followed up on Resident #1 being started on an or monitored the effect on the resident. The DON said medication could increase potential for . The DON agreed there was no documentation Resident #1's HCP was notified of the medication.

On at 12:43 p.m., the Administrator said the process should be to notify the daughter that resident was placed on .

No progress notes were found in the chart for . Progress notes on , written by (Staff A) Registered Nurse (RN) indicated the following:
"2:26 p.m., Resident has , verbalized right . PRN , medication given, assisted to bed, and assessed, able to move left extremity WNL (Within Normal Limits), not able to move right without and touching right area. MD notified and order for ,

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A 025	Continued From page 4	A 025		

received. 3:08 p.m., New order from Dr. to decrease , from 25 mg twice a day to 12.5 mg twice a day."

"9:49 p.m., , came and obtained right , , received results 9:49 p.m. Right subcapital with modest displacement. Resident given PRN medication as ordered, resident verbalizes painful to move right and verbalizes no , when resting. MD and family notified by phone. Resident resting, awaiting MD callback."

"10:00 p.m., Resident #1's skin assessed, right dry, red 1.5cm x 1.5 cm, to touch, left dark discolored brown area, right dark discolored brown area, right and right upper arm discolored red areas , . Able to move upper extremities within normal limits, no , . Order to send to ER for right , . arrived 10:45 p.m. and transported resident to ER, daughter notified by phone, no answer, message left requesting call ."

On at 11:39 a.m., Staff A said she only worked on the weekends and said she took care of Resident #1 on Saturday and Sunday . Staff A said when she came in on Saturday, she noticed Resident #1 was sitting in a wheelchair, but did not think anything was different as Resident #1 did not say she was in any , and she did not appear to have any , , no grimaces, just smiling and pleasant. Staff A said she asked the aides what she was doing in the wheelchair and they said she did not want to get up and the wheelchair was in her private sitting area, so they put her in the wheelchair to get her to breakfast. Staff A said she felt maybe Resident #1 was just feeling weak. Staff A said she wheeled Resident #1 out for a visit with her

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daughter on Saturday and at dinner Resident #1 was still in the wheelchair, but she still felt all was normal with Resident #1 as she was seated in the wheelchair as she always sat. Staff A said she did no physical assessment on Saturday even though Resident #1 was seated in a wheelchair and was normally ambulatory. Staff A did not know who placed Resident #1 in the wheelchair that day. Staff A said on Sunday Resident #1's daughter came to visit again and when she went to wheel her out there, Resident #1 said no, then Staff A asked her if she wanted to see her daughter and she said yes, and Staff A proceeded to wheel her out to the visit. Staff A said after lunch, Resident #1 was slumped over in her wheelchair and said ouch, so Staff A took her to her room. Staff A said 3 staff members assisted Resident #1 into her bed, and after assessment the right , looked as if it could have been a tad bit shorter, when she repositioned her to do further assessment, she said ouch again. Staff A said she called the doctor who ordered an , and after the , results came in she was sent out.

On at 12:03 p.m., Staff B (caregiver) said she did not work on Saturday . She said when she came to work on Sunday at approximately 3:50 p.m., she helped Resident #1 get out of bed. She said Resident #1 said she was in , so she put her in a wheelchair that was in the room. Staff B said she was not aware if Resident #1 was a risk, but knew she had a walker. She said she had never witnessed Resident #1 have a .

On at 12:11 p.m., The Administrator said the staff member who got Resident #1 out of bed on Saturday , no longer

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A 025	Continued From page 6 worked for the company. The Administrator said she interviewed the former staff member on and the former staff member told her Resident #1 was already up in a wheelchair and night shift had not reported any . The former staff member told the Administrator when she arrived on Saturday ( ), Resident #1 did not want to get out of the wheelchair for breakfast. The former staff member said she toileted Resident #1 at approximately 1:00 p.m. on Saturday and she did not notice any , but the resident had long pants on. The former staff member said on Sunday Resident #1 would not stand up and assistance was needed from another aide. Resident #1 told her "don't touch me" and that was when the former staff member told the nurse on duty. Administrator said she had no witness or report of a by Resident #1. The Administrator said the wheelchair in Resident #1's room may have belonged to her husband who also had been a resident but had , recently. On at 3:30 p.m., the Administrator agreed a normally ambulatory resident suddenly only using a wheelchair could be a significant change and should warrant an assessment for potential injury and that Resident #1 was not assessed for injury until the second day. Class III	A 025		