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
	AL11968448	A. BUILDING: _____ B. WING _____	06/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENADES BY -WEST ORANGE	720 ROPER ROAD WINTER GARDEN, FL 34787

(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 Complaint Investigation #2021008067 was conducted on , and Serenades by -West Orange had deficiencies at the time of the survey.	A 000		
A 025 SS=J	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) Monitoring of the quantity and quality of resident diets in accordance with rule	A 025		

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A 025	Continued From page 1 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, medical record review and interview, the facility failed to provide adequate supervision to meet the needs of 1 of 4 sampled memory care residents who was left unsupervised in the sun, outdoors in the courtyard for 3 hours, and sustained hyperthermia with a temperature of 106.8 degrees Fahrenheit (#3). Findings: Resident #3's record revealed he was admitted to the facility on with diagnoses of , and	A 025		

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A 025	Continued From page 2 . . . . . The resident's health assessment form 1823 was not dated and noted diagnosis that included . . . . . The resident was noted to be with some agitation. Upon admission, he ambulated independently using a walker. He was alert and responsive, able to make needs known, and able to follow instructions. Resident #3's record reflected he had resided in a secured memory care building from the time of admission until his transfer to the hospital on . The resident's record listed the following medications: * , { } 12.5 milligrams (mg.) - severe sweating, ... , or . . . . . , can increase the risk for , ... while taking this medication. "Avoid becoming overheated or , during exercise and in hot weather." (drugs.com . . . . . , . . .). * , 10 mg. 1 at bedtime (,) - more likely to lose too much salt (hyponatremia), especially if they are also taking "water pills" (. . . . .) with this medication; loss of coordination can increase the risk of falling. (drugs.com . . . . . , ...). " . . . . . , drowsiness .... , ... , , , . . . , fatigue ...." (webMD.com . . . . . ,). The facility's admission and discharge log reflected that the resident was admitted on and discharged on . The reason for discharge was "went to hospital-expired ." A facility internal report, submitted to the Agency for Health Care Administration (AHCA) on , revealed the following information concerning at resident #3. On via the community's camera:	A 025		

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A 025	Continued From page 3 2 PM - resident #3 entered the courtyard 2:47 PM - a caregiver (CG) entered the courtyard, approached the resident, spoke to him, then left the courtyard. 5 PM - the Lifestyle Director (activities director) reported that License Practical Nurse (LPN) D asked if she saw resident #3. Then, the administrator immediately announced an "all . . . . -on deck" search for resident #3. 5:01 PM - the business office manager located the resident in the courtyard, and Emergency Medical Services ( ) was called. A facility internal report, submitted to AHCA on . . . . . , noted the same outcome as the facility internal report dated . The analysis noted: "Resident in community courtyard for 3 hours, staff checked on resident after being in courtyard for 1.5 hours later resident said he was ok and asked to stay in courtyard. Resident observed in courtyard at a later time unresponsive." Corrective action on read, "Staff hourly checks in on each resident location, meal . . . count check in, restricted courtyard at times of inclement weather, and in-service staff on rounding at shift change." The internal investigation that was conducted resulted in termination of LPN D and CG C. On at 12 PM, the administrator said LPN D and CG C were terminated after the incident because they did not follow the facility's policies when the resident was missing. The administrator said upon review of the cameras, the following was seen. Resident #3 sat outside in the courtyard on the Adagio side where he resided in the shaded area. The resident later moved to another area of the courtyard that had direct sun exposure. CG A, who worked 7 AM-3 PM, informed CG C, who worked the PM	A 025		

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A 025	Continued From page 4 shift, that resident #3 was in the courtyard and did not want to come inside. CG A informed CG C at the change of shift to check on resident #3. According to the administrator, CG C reported to LPN D that she could not locate the resident around 4:30 PM. LPN D did not inform the administrator until 5 PM that the resident was missing. Resident #3 was found passed out on the courtyard and transported to the hospital via The PM CG C's written timeline reflected the following: 3 PM - rounds with CG A - there was a resident who was soiled, and she requested CG A's help to clean the resident. Rounds ended and CG A left for the day. 4 PM - CG C started providing medications. 4:15 PM - CG C looked for resident #3, looked in sign out book, looked in his apartment, looked in the bathroom, and in courtyard but did not see him. At this time CG C came through the Adagio unit and reported to LPN D that she could not locate resident #3. LPN D asked if CG C searched the bathroom, and LPN D continued to walk through the Adagio unit towards B. 4:30 PM - LPN D re-entered Adagio and asked CG C if she found the resident. She informed her she did not know where he was. LPN D left the Adagio unit via the courtyard doors. At that point, CG C continued caring for residents and radioed LPN D at 5:15 PM she needed assistance due to resident in the neighborhood. According to CG C's documentation, she informed LPN D at 4:15 PM that resident #3 was missing, and the resident was not found until around 5 PM. On at 1:40 PM, CG A said at the change of 7 AM-3 PM shift, she informed CG C,	A 025		

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A 025	Continued From page 5 who worked the PM shift, that she tried to bring resident #3 inside but he did not want to come inside. She said she told CG C to check on him. CG A said the resident was sitting on the bench by the Adagio side under the covered shaded area. On at 1:50 PM, CG B said during the shift change, she overheard staff telling CG C that resident #3 would not come inside. She said she went outside to the area before she left and tried to bring him in before she left for the day, but the resident told her he was alright and wanted to stay outside. On at 2:30 PM via telephone, LPN D stated she was the nurse who worked the PM shift on . LPN D said she arrived to work before 3 PM on and did not see resident #3 in the common area where he normally watched TV. She said this did not concern her because resident #3 liked to be in his room to watch TV. She said around 4:30 PM, CG C told her she could not find resident #3 anywhere. LPN D said CG C told her she had checked the front desk book to see if he left with his family. She said she started looking for the resident through the Adagio unit and could not find him. LPN D went to the front desk to check the sign-out book for herself. She said she asked the receptionist if he was out, and the receptionist told her she did not see him leave with anyone. She said when she was headed , she ran into the Activities Director and asked her if she had seen resident #3. She said the Activities Director had not seen resident #3. She said, later the administrator commanded everyone in the facility to start looking for the resident. She said while she checked the Brio unit, she received a call to come to the patio. She stated resident #3	A 025		

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A 025	Continued From page 6 was found breathing but unresponsive and on lying on his right side. His skin was warm and dry and . . . . was on the ground. Some staff members were already there when she got there. She said she told them to stay with the resident until she went to the nurse's office to call 911. She said someone had already called because by the end of her call to 911 they were already there. She said the staff put fresh water on the resident's skin and held a blanket over him to provide extra shade. A copy of the facility's timeline taken from . . video was provided as follows: 2 PM - resident #3 seen via community cameras entering community courtyard with another resident. 2:47 PM - seen via community camera CG B entered courtyard, approached resident #3 and was talking to him, turned, and left and went into community via Adagio neighborhood 4:20 PM - resident #3 witnessed via camera going down on right side on bench is now unable to be seen via camera. 4:30 PM - CG C informed LPN D that she could not find resident #3 in Adagio neighborhood. At this time, the Administrator said LPN D and CG C should have reported to the administrator, but they did not. 5 PM - notified that Lifestyle Director E said that LPN D approached her coming out of her office asking if she saw resident #3. 5 PM - executive director (ED)/administrator announced over radio all on-deck search for resident #3. 5:01 PM - resident #3 was found in the courtyard by the Business Office Director 5:11 PM - arrived. Review of the facility's hydration timeline for	A 025		

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A 025	Continued From page 7 resident #3 on . . . . . was as follows: 8 AM - Breakfast: water orange juice, milk with cereal 11:30 AM - Lunch: water, Gatorade 1 PM - Attended Activity: a cup of Gatorade and a cookie. Observations during the tour of the facility on . . . . . revealed the building was a secured memory care building that consisted of 3 named sections; each section required a code to enter. There was water located in the kitchen on each section that residents could access. There were no residents observed on the patio. On at 7:52 PM, LPN D's documentation reflected the following. "By 5 PM, resident #3 was found breathing but unresponsive on his right side, on a bench on the patio. was noted on the floor, and his skin was warm. The nurse on duty requested the resident assistant and staff members to stay with the resident. 911 was called. Staff put fresh water on resident's skin and held a towel over him to provide extra shade. The resident's . . . . , was , and was 200, per paramedics. . . . took the resident to the hospital for further evaluation." On at 3 PM, the administrator said facility interventions were put in place after the incident, and all staff had received training regarding elopement procedure. She said that as soon as a resident is discovered missing, they would immediately report it so that all staff could start the search. She stated CG C did not immediately report resident #3 missing. She said after the incident, residents would not be allowed to be out during times of inclement weather, and when they were outside, staff would	A 025		

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A 025	Continued From page 8 monitor them. The facility's documentation did not reveal documentation that noted the facility had implemented any procedures for hydration availability while residents were outside, and the type of supervision to be provided while outside in the courtyard. Resident #3's Hospital Medical Record revealed the following: - Hospitalist inpatient history and physical - " - patient found unresponsive, on a bench in the sun, at an assisted living facility (ALF). His initial temperature was 106.8 degrees Fahrenheit. The patient, who has a history of , presented to the hospital via ambulance after he was found in a courtyard at the memory facility. The patient was unable to provide any type of history. We do not know how long he was on the ground; he was outdoors. Per when they found him his temperature was 107 degrees Fahrenheit, in the emergency room; he was cooled off with some ice and fluids." On at 5:48 PM, his temperature was 105 degrees Fahrenheit. The lab report noted his was 203 (High), CO 2 was 18 (Low), was 55 (High), and 2.86 (High). "A high level means your aren't working well. But elevated can also be due to .... , resulting from not drinking enough fluids or for other reasons ....Certain medications ...." (www.mayoclinic.org). "Causes of high levels: or inadequate water intake such as high , sweating, diuresis can cause concentration and reduced flow in the ...." (www. .com).	A 025		

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A 025	Continued From page 9	A 025		

- History of Present Illness noted Acute illness. The doctor noted per the resident's son that he was doing fine yesterday during a visit, . The resident moved from another state about a week ago to live at the ALF. He ambulated with a walker, could feed himself and had but was normally conversational. Upon arrival to the emergency department, the resident was tachycardic (rapid heartbeat), tachypneic (rapid ,), of one 105 degrees . The physician noted he was worried about a . In the emergency department the resident has a episode. The physician noted he was worried that the resident may have aspirated. The resident had an episode in the emergency department where he had tonic activity of the upper extremities , and some low amplitude -like activity of the upper extremities , and some low amplitude -like activity of the left lower extremity.

Hospital inpatient progress notes dated revealed the following.
General: Unresponsive, appears to be sleeping : unresponsive with tome occasional tremor and twitches are noted
Skin: warm and dry, pink discoloration is noted on the left side of his body involving the , lateral , , also the medical aspect of the right and right , were noted as well
The assessment plan noted:
Principle Problem: Acute illness
1. Hyperthermia, uncertain origin, versus physical due to heat are both possible.
2. failure, unknown , most likely
3. Elevated , most likely

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A 025	Continued From page 10 4. Mildly elevated troponin, possible acute injury 5. acidosis with increased anion gap, most likely secondary to prolonged immobile state 6. Acute tissue injury, secondary to prolonged time on ground, with developing on all pressure points over the joints. The physician's note read, "The patient would be admitted to the hospital for comfort measures only because his family member did not desire any type of aggressive intervention. Family was referred to hospice agencies. Prognosis is very poor, mortality suspected. Disposition-discharge to hospice inpatient." care consult notes documented on , revealed were present on admission: right anterior medial , right anterior-open , left anterior , right upper , medial, left upper lateral , left (3) lateral , lateral left lower , left lateral , , left open ; right , and right anterior arm . There was no documentation found in the facility record that indicated resident #3 was admitted with or had on his body during his 6-day ALF stay prior to the hospital's documentation. Review of the hospice notes revealed resident #3 was admitted to hospice inpatient care on and , on . The facility failed to provide adequate supervision for a resident who sat in the courtyard of the facility and allowed him to remain there unattended for 3 hours. There was no documented evidence that the resident was	A 025		

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A 025	Continued From page 11 checked at any time after 2:47 PM when the 7 AM to 3 PM staff checked on him. The resident was found unresponsive, 911 was called, and the resident was transported to the hospital. According to the hospital records, the Emergency Medical Services ( ) reported the resident had a temperature of 107 degrees Fahrenheit upon arrival at the facility. Review of weather.com on . . . . reflected that the high temperature was 82 degrees Fahrenheit. The resident was transferred to inpatient hospice care on and , , on . The facility did not address the issue of supervision of residents, specifically of residents being supervised while outside in the courtyard. The Emergency Medical Services Report was requested on and but had not been received as of . . . . . . Class I	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	A 165		

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A 165	Continued From page 12 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 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.	A 165		

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A 165	Continued From page 13 (6) [redacted], neglect, or [redacted] 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 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	A 165		

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
	AL11968448	A. BUILDING: _____ B. WING _____	06/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENADES BY -WEST ORANGE	720 ROPER ROAD WINTER GARDEN, FL 34787

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A 165	Continued From page 14 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 facility internal report and interview, the facility failed to report neglect to the Department of Children and Family as required under Chapter 415. Finding: Review of a facility internal report submitted to the Agency for Health Care Administration (AHCA) on revealed the facility noted the outcome of the incident was 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. The narrative noted that resident #3 was observed on via the community's camera entering the courtyard at around 2 PM. At 2:47 PM, a caregiver was observed entering the courtyard approaching the resident and talking to him. She turned away and left the courtyard. At 5 PM, the Lifestyle Director (activities director) reported that a License Practical Nurse (LPN) approached her asking if she saw resident #3.	A 165		

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A 165	Continued From page 15 The administrator immediately announced -on deck search for resident #3. At 5:01 PM, the resident was located in the courtyard by the business office manager. 911 was called. A facility internal report, submitted on . . . . . , noted the same outcome as the facility internal report. The analysis noted: "Resident in community courtyard for 3 hours; staff checked on resident after being in courtyard for 1.5 hours; resident said he was ok and asked to stay in courtyard. Resident observed in courtyard at a later time unresponsive." Corrective action noted: Staff hourly checks in on each resident location. Meal count check in. Restricted courtyard at times of inclement weather. In-service staff on rounding at shift change. Internal investigation conducted resulting in termination of an LPN and Medication Technician Caregiver Resident #3 resided in a secured memory care building. On . . . . . at 12 PM, the administrator said LPN D and Medication Technician Caregiver C were terminated due to the incident because they did not follow the facility's policies to report immediately when the resident was discovered to be missing, so a search of the facility could have been initiated. She said caregiver (CG) A who worked 7 AM-3 PM informed CG C, who worked the 3 PM-11 PM shift, that resident #3 was in the courtyard and did not want to come inside. She informed CG C at the change of shift to check on the resident. She said CG C reported to LPN D that she could not locate the resident around 4:30 PM. LPN D did not inform the administrator until 5 PM that the resident was missing. The resident was found passed out in the courtyard and	A 165		

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A 165	Continued From page 16 transported to the hospital. She said the resident was admitted into the hospital and , under hospice care. The facility did not include in Adverse Incident Report that resident #3 had , . The administrator said she was informed by a corporate nurse that reporting to AHCA was sufficient and she did not report this incident to the Department of Children and Family (DCF) to investigate the negligence. A report was made to DCF on by the AHCA surveyor and was accepted for investigation. Review of hospice notes revealed the resident was admitted to inpatient hospice service on and , on . Class III	A 165		