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
	AL11969275	A. BUILDING: _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASIDE AT FORT MYERS	15800 BEACHWALK BLVD FORT MYERS, FL 33908

(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
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 available 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: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar 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 available 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. 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 available 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 electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on	CZ821		

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CZ821	Continued From page 2 Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available 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. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section	CZ821		

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CZ821	Continued From page 3 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500. (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 review, and staff interviews, the facility failed to file the electronic 1 day or 15 day adverse incident reports as required for 1 (Resident #1) of 3 resident records reviewed for adverse incidents. The resident suffered unreported blunt force . . . . , was not assessed by the facility nurse after receiving report of the injuries and later found to have expired due to complications of a . The findings included: Review of the Medical Examiner's Report for Resident #1 dated . . .. , revealed (a) cause of : complications of . , (b) due to: blunt . . . . . . Review of Nursing Policies & Procedures, manual section: Emergency Care, Policy Name: Unusual Occurrence. Effective date: . . . . , "Policy: All unusual instances or occurrences related to the	CZ821		

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CZ821	Continued From page 4	CZ821		

care of the resident will be immediately reported. Procedure 1. Nursing staff will closely monitor and document the behavior and condition of the resident involved to check for any injury and to prevent reoccurrence of the incident. This is to be documented on an Incident Report. 2. The person in charge will notify the following for the residents involved in the incident: a. the attending physician, b. responsible party, c. Director of Clinical Services."

Interview on at 1:15 p.m., the Hope Hospice Nurse said on a routine visit on , was noted on Resident #1's upper going down to the , and she immediately notified the facility's Licensed Practical Nurse (LPN) Staff C.

Interview on at 2:10 p.m., the Director of Clinical Services (DCS) said he received no reports from facility staff regarding the on Resident #1. He said the first time he heard about the on Resident #1, was after Resident #1 was transferred to hospice on . He said he was notified by the hospice house supervisor of the on Resident #1, he then went over to the facility to assess Resident #1. He said before being transferred to Hospice House Resident #1 was bedridden and non- . He had not received any reports of Resident #1 having had a ; she lived in the memory care unit and was to have hourly checks by facility staff. The DCS confirmed there is no documentation indicating Resident #1's representative was notified of the . He said an investigation was performed and indicated LPN Staff C and previous LPN Staff G were notified of the by the hospice nurse on and did not input any document in Resident #1's clinical record. He confirmed there

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CZ821	Continued From page 5 was no documentation indicating Resident #1 was being checked on hourly as required by the facility staff, and there is no documentation that Resident #1 was assessed by Staff C and Staff G after receiving reports of the [illegible] on Resident #1. He confirmed the concern was not reported to any state agencies. Interview on [illegible] at 2:55 p.m., the Memory Care Director (MCD) said Staff C and Staff G should have assessed, documented and reported to her after receiving report of the [illegible] on Resident #1. She did not receive any reports. She only found out about the [illegible] after Resident #1 was transferred to Hospice House. Interview on [illegible] at 3:55 p.m., LPN Staff C confirmed receiving the report from the Hospice Nurse of [illegible] on Resident #1. She did not report to the Director of Memory Care. She did not document in Resident #1's clinical record; nor did she go and assess or observe Resident #1 for the [illegible]. Interview on [illegible] at 4:50 p.m., former employee LPN Staff G confirmed the report was given to him about the [illegible] on Resident #1 and he did not document in the clinical record, nor did he assess for treatment or observe Resident #1 for the [illegible]. Interview on [illegible] at 5:15 p.m., the Advanced Practical Registered Nurse (APRN), she said the first time she saw the [illegible] on Resident #1 was upon admission to the Hospice House, and in her professional opinion it looked like [illegible] or even [illegible], so the team at hospice collectively recorded the [illegible] as they felt it led to Resident #1's decline/[illegible]	CZ821		

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CZ821	Continued From page 6 **Photographic evidence provided by Hospice nursing staff** Class III	CZ821		

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A 000	Initial Comments An unannounced complaint survey #2021004984 was conducted on [redacted] at Seaside at Fort Myers, an assisted living facility in Fort Myers, Florida. Complaint #2021004984 was substantiated at A0025, A0165, and CZ821. The following is a 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, and interview, the facility failed to provide care and services appropriate to the needs of residents and maintain a general awareness of the resident's general health, safety, physical and emotional wellbeing. The facility failed to maintain a written record, updated as needed for significant changes that results in medical attention for 1 (Resident #1) of 3 resident records reviewed. Failure of timely reporting and assessment potentially contributed to the	A 025		

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A 025	Continued From page 2 complications resulting in . . . . . The findings included: Review of Medical Examiner Report for Resident #1 dated revealed Date of : . . . . , (a) cause of . . . : complications of , (b) due to: blunt . Review of Nursing Policies & Procedures, manual section: Emergency Care, Policy Name: Unusual Occurrence. Effective date: , "Policy: All unusual instances or occurrences related to the care of the resident will be immediately reported. Procedure 1. Nursing staff will closely monitor and document the behavior and condition of the resident involved to check for any injury and to prevent reoccurrence of the incident. This is to be documented on an Incident Report. 2. The person in charge will notify the following for the residents involved in the incident: a. the attending physician, b. responsible party, c. Director of Clinical Services." Interview on . . . at 1:15 p.m., the Hope Hospice Nurse said on a routine visit on , ... was noted on Resident #1's upper going down to the , and she immediately notified the facility's Licensed Practical Nurse (LPN) Staff C. Interview on at 2:10 p.m., the Director of Clinical Services (DCS) said he received no reports from facility staff regarding the on Resident #1 on . . . . . . He said the first time he heard about the on Resident #1, was after Resident #1 was transferred to hospice on . He said he was notified by the hospice house supervisor of the on Resident #1; he then went over to the facility to assess	A 025		

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A 025	Continued From page 3 Resident #1. He said before being transferred to Hospice House Resident #1 was bedridden and non- ᵕ . He had not received any reports of Resident #1 having had a ; she lived in the memory care unit and was to have hourly checks by facility staff. The DCS confirmed there is no documentation indicating Resident #1's representative was notified of the ᵕ. He said an investigation was performed and indicated LPN Staff C and former employee LPN Staff G were notified of the ᵕ by the hospice nurse on and did not input any document in Resident #1's clinical record. He confirmed there was no documentation indicating Resident #1 was being checked on hourly as required by the facility staff, and there is no documentation that Resident #1 was assessed by Staff C and Staff G after receiving reports of the ᵕ on Resident #1. He confirmed the concern was not reported to any state agencies. Interview on at 2:55 p.m., the Memory Care Director (MCD) said Staff C and Staff G should have assessed, documented and reported to her after receiving report of the ᵕ on Resident #1 on . She did not receive any reports. She only found out about the ᵕ after Resident #1 was transferred to Hospice House on . Interview on at 3:10 p.m., Caregiver Staff A said she provided care to Resident #1 on the 6:00 a.m. - 2:00 p.m. shift on , noted the ᵕ and reported to Staff C and brought Staff C into the room to observe Resident #1, and Staff C informed her she would make a report of it. Interview on at 3:55 p.m., LPN Staff C confirmed receiving the report from the Hospice Nurse of ᵕ on Resident #1 on . She	A 025		

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A 025	Continued From page 4 did not report to the Director of Memory Care. She did not document in Resident #1's clinical record; nor did she go and assess or observe Resident #1 for the . Interview on at 4:15 p.m., Caregiver Staff D said she observed the on Resident #1 and reported it to LPN Staff G and nothing was done. Interview on at 4:25 p.m., Certified Nurse Assistant (CNA) Staff E, she said she noted the on Resident #1 and Staff C was informed. She said she did not document the as the nurse is required to document in the clinical records. Interview on at 4:35 p.m., CNA Staff F said she was informed of the on Resident #1 when she came on duty on for the overnight shift 11:00 p.m. - 7:00 a.m. She said no instructions were given for treatment for the on Resident #1. Interview on at 4:50 p.m., former employee LPN Staff G confirmed the report was given to him about the on Resident #1 and he did not document in the clinical record, nor did he assess for treatment or observe Resident #1 for the . Interview on at 3:20 p.m., the DCS said he has no information regarding the investigation that was performed pertaining to the on Resident #1. The previous Executive Director had all the information of the entire investigation. He confirmed the facility should have documented in the clinical record and followed up on the concern when reported to staff and no one did anything. There was no documentation and	A 025		

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A 025	Continued From page 5 no follow through from facility staff. He confirmed the facility did not report to any state agencies. Interview on at 5:15 p.m., the Advanced Practical Registered Nurse (APRN), she said the first time she saw the on Resident #1 was upon admission to the Hospice House, and in her professional opinion it looked like or even , so the team at hospice collectively recorded the as they felt it led to Resident #1's decline/ . **Photographic evidence provided by Hospice nursing staff** 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) An event over which facility personnel could	A 165		

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A 165	Continued From page 6 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 Families as required under chapter 415.	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969275	A. BUILDING: _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASIDE AT FORT MYERS	15800 BEACHWALK BLVD FORT MYERS, FL 33908

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A 165	Continued From page 7 (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 1 business day after the incident pursuant to rule	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 165	Continued From page 8 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 review, and staff interviews, the facility failed to file 1 day or 15 day adverse incident reports as required for 1 (Resident #1) of 3 resident records reviewed for adverse incidents. The resident suffered unreported blunt force , was not assessed by the facility nurse after receiving report of the injuries and later found to have expired due to complications of a . The findings included: Review of the Medical Examiner's Report for Resident #1 dated , revealed (a) cause of : complications of , (b) due to: blunt . Review of Nursing Policies & Procedures, manual section: Emergency Care, Policy Name: Unusual Occurrence. Effective date: , "Policy: All unusual instances or occurrences related to the care of the resident will be immediately reported. Procedure 1. Nursing staff will closely monitor and document the behavior and condition of the resident involved to check for any injury and to prevent reoccurrence of the incident. This is to be documented on an Incident Report. 2. The person in charge will notify the following for the residents involved in the incident: a. the attending	A 165		

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A 165	Continued From page 9 physician, b. responsible party, c. Director of Clinical Services." Interview on at 1:15 p.m., the Hope Hospice Nurse said on a routine visit on , was noted on Resident #1's upper going down to the , and she immediately notified the facility's Licensed Practical Nurse (LPN) Staff C. Interview on at 2:10 p.m., the Director of Clinical Services (DCS) said he received no reports from facility staff regarding the on Resident #1. He said the first time he heard about the on Resident #1, was after Resident #1 was transferred to hospice on . He said he was notified by the hospice house supervisor of the on Resident #1, he then went over to the facility to assess Resident #1. He said before being transferred to Hospice House Resident #1 was bedridden and non- . He had not received any reports of Resident #1 having had a ; she lived in the memory care unit and was to have hourly checks by facility staff. The DCS confirmed there is no documentation indicating Resident #1's representative was notified of the . He said an investigation was performed and indicated LPN Staff C and previous LPN Staff G were notified of the by the hospice nurse on and did not input any document in Resident #1's clinical record. He confirmed there was no documentation indicating Resident #1 was being checked on hourly as required by the facility staff, and there is no documentation that Resident #1 was assessed by Staff C and Staff G after receiving reports of the on Resident #1. He confirmed the concern was not reported to any state agencies.	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 165	Continued From page 10 Interview on at 2:55 p.m., the Memory Care Director (MCD) said Staff C and Staff G should have assessed, documented and reported to her after receiving report of the on Resident #1. She did not receive any reports. She only found out about the after Resident #1 was transferred to Hospice House. Interview on at 3:55 p.m., LPN Staff C confirmed receiving the report from the Hospice Nurse of on Resident #1. She did not report to the Director of Memory Care. She did not document in Resident #1's clinical record; nor did she go and assess or observe Resident #1 for the . Interview on at 4:50 p.m., former employee LPN Staff G confirmed the report was given to him about the on Resident #1 and he did not document in the clinical record, nor did he assess for treatment or observe Resident #1 for the . Interview on at 5:15 p.m., the Advanced Practical Registered Nurse (APRN), she said the first time she saw the on Resident #1 was upon admission to the Hospice House, and in her professional opinion it looked like or even , so the team at hospice collectively recorded the as they felt it led to Resident #1's decline/ . **Photographic evidence provided by Hospice nursing staff** Class III	A 165		

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CZ821	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 available 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: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar 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 available 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. 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 available 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 electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on	CZ821		

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CZ821	Continued From page 2 Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available 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. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section	CZ821		

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CZ821	Continued From page 3 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500. (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 review, and staff interviews, the facility failed to file the electronic 1 day or 15 day adverse incident reports as required for 1 (Resident #1) of 3 resident records reviewed for adverse incidents. The resident suffered unreported blunt force . . . . , was not assessed by the facility nurse after receiving report of the injuries and later found to have expired due to complications of a . The findings included: Review of the Medical Examiner's Report for Resident #1 dated . . .. , revealed (a) cause of : complications of . , (b) due to: blunt . . . . . Review of Nursing Policies & Procedures, manual section: Emergency Care, Policy Name: Unusual Occurrence. Effective date: . . . . , "Policy: All unusual instances or occurrences related to the	CZ821		

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CZ821	Continued From page 4	CZ821		

care of the resident will be immediately reported. Procedure 1. Nursing staff will closely monitor and document the behavior and condition of the resident involved to check for any injury and to prevent reoccurrence of the incident. This is to be documented on an Incident Report. 2. The person in charge will notify the following for the residents involved in the incident: a. the attending physician, b. responsible party, c. Director of Clinical Services."

Interview on at 1:15 p.m., the Hope Hospice Nurse said on a routine visit on , was noted on Resident #1's upper going down to the , and she immediately notified the facility's Licensed Practical Nurse (LPN) Staff C.

Interview on at 2:10 p.m., the Director of Clinical Services (DCS) said he received no reports from facility staff regarding the on Resident #1. He said the first time he heard about the on Resident #1, was after Resident #1 was transferred to hospice on . He said he was notified by the hospice house supervisor of the on Resident #1, he then went over to the facility to assess Resident #1. He said before being transferred to Hospice House Resident #1 was bedridden and non- . He had not received any reports of Resident #1 having had a ; she lived in the memory care unit and was to have hourly checks by facility staff. The DCS confirmed there is no documentation indicating Resident #1's representative was notified of the . He said an investigation was performed and indicated LPN Staff C and previous LPN Staff G were notified of the by the hospice nurse on and did not input any document in Resident #1's clinical record. He confirmed there

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CZ821	Continued From page 5 was no documentation indicating Resident #1 was being checked on hourly as required by the facility staff, and there is no documentation that Resident #1 was assessed by Staff C and Staff G after receiving reports of the [illegible] on Resident #1. He confirmed the concern was not reported to any state agencies. Interview on [illegible] at 2:55 p.m., the Memory Care Director (MCD) said Staff C and Staff G should have assessed, documented and reported to her after receiving report of the [illegible] on Resident #1. She did not receive any reports. She only found out about the [illegible] after Resident #1 was transferred to Hospice House. Interview on [illegible] at 3:55 p.m., LPN Staff C confirmed receiving the report from the Hospice Nurse of [illegible] on Resident #1. She did not report to the Director of Memory Care. She did not document in Resident #1's clinical record; nor did she go and assess or observe Resident #1 for the [illegible]. Interview on [illegible] at 4:50 p.m., former employee LPN Staff G confirmed the report was given to him about the [illegible] on Resident #1 and he did not document in the clinical record, nor did he assess for treatment or observe Resident #1 for the [illegible]. Interview on [illegible] at 5:15 p.m., the Advanced Practical Registered Nurse (APRN), she said the first time she saw the [illegible] on Resident #1 was upon admission to the Hospice House, and in her professional opinion it looked like [illegible] or even [illegible], so the team at hospice collectively recorded the [illegible] as they felt it led to Resident #1's decline/[illegible]	CZ821		

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CZ821	Continued From page 6 **Photographic evidence provided by Hospice nursing staff** Class III	CZ821		

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A 000	Initial Comments An unannounced complaint survey #2021004984 was conducted on [redacted] at Seaside at Fort Myers, an assisted living facility in Fort Myers, Florida. Complaint #2021004984 was substantiated at A0025, A0165, and CZ821. The following is a description of the deficiencies.	A 000		
A 025	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		

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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, and interview, the facility failed to provide care and services appropriate to the needs of residents and maintain a general awareness of the resident's general health, safety, physical and emotional wellbeing. The facility failed to maintain a written record, updated as needed for significant changes that results in medical attention for 1 (Resident #1) of 3 resident records reviewed. Failure of timely reporting and assessment potentially contributed to the	A 025		

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	AL11969275	A. BUILDING: _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASIDE AT FORT MYERS	15800 BEACHWALK BLVD FORT MYERS, FL 33908

(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 025	Continued From page 2 complications resulting in . . . . . The findings included: Review of Medical Examiner Report for Resident #1 dated revealed Date of : . . . . , (a) cause of . . . : complications of . . . , (b) due to: blunt . Review of Nursing Policies & Procedures, manual section: Emergency Care, Policy Name: Unusual Occurrence. Effective date: , "Policy: All unusual instances or occurrences related to the care of the resident will be immediately reported. Procedure 1. Nursing staff will closely monitor and document the behavior and condition of the resident involved to check for any injury and to prevent reoccurrence of the incident. This is to be documented on an Incident Report. 2. The person in charge will notify the following for the residents involved in the incident: a. the attending physician, b. responsible party, c. Director of Clinical Services." Interview on . . . at 1:15 p.m., the Hope Hospice Nurse said on a routine visit on , ... was noted on Resident #1's upper going down to the , and she immediately notified the facility's Licensed Practical Nurse (LPN) Staff C. Interview on at 2:10 p.m., the Director of Clinical Services (DCS) said he received no reports from facility staff regarding the on Resident #1 on . . . . . . He said the first time he heard about the on Resident #1, was after Resident #1 was transferred to hospice on . He said he was notified by the hospice house supervisor of the on Resident #1; he then went over to the facility to assess	A 025		

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A 025	Continued From page 3 Resident #1. He said before being transferred to Hospice House Resident #1 was bedridden and non- ◡. He had not received any reports of Resident #1 having had a ; she lived in the memory care unit and was to have hourly checks by facility staff. The DCS confirmed there is no documentation indicating Resident #1's representative was notified of the ◡. He said an investigation was performed and indicated LPN Staff C and former employee LPN Staff G were notified of the ◡ by the hospice nurse on and did not input any document in Resident #1's clinical record. He confirmed there was no documentation indicating Resident #1 was being checked on hourly as required by the facility staff, and there is no documentation that Resident #1 was assessed by Staff C and Staff G after receiving reports of the ◡ on Resident #1. He confirmed the concern was not reported to any state agencies. Interview on at 2:55 p.m., the Memory Care Director (MCD) said Staff C and Staff G should have assessed, documented and reported to her after receiving report of the ◡ on Resident #1 on . She did not receive any reports. She only found out about the ◡ after Resident #1 was transferred to Hospice House on . Interview on at 3:10 p.m., Caregiver Staff A said she provided care to Resident #1 on the 6:00 a.m. - 2:00 p.m. shift on , noted the ◡ and reported to Staff C and brought Staff C into the room to observe Resident #1, and Staff C informed her she would make a report of it. Interview on at 3:55 p.m., LPN Staff C confirmed receiving the report from the Hospice Nurse of ◡ on Resident #1 on . She	A 025		

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A 025	Continued From page 4 did not report to the Director of Memory Care. She did not document in Resident #1's clinical record; nor did she go and assess or observe Resident #1 for the . Interview on at 4:15 p.m., Caregiver Staff D said she observed the on Resident #1 and reported it to LPN Staff G and nothing was done. Interview on at 4:25 p.m., Certified Nurse Assistant (CNA) Staff E, she said she noted the on Resident #1 and Staff C was informed. She said she did not document the as the nurse is required to document in the clinical records. Interview on at 4:35 p.m., CNA Staff F said she was informed of the on Resident #1 when she came on duty on for the overnight shift 11:00 p.m. - 7:00 a.m. She said no instructions were given for treatment for the on Resident #1. Interview on at 4:50 p.m., former employee LPN Staff G confirmed the report was given to him about the on Resident #1 and he did not document in the clinical record, nor did he assess for treatment or observe Resident #1 for the . Interview on at 3:20 p.m., the DCS said he has no information regarding the investigation that was performed pertaining to the on Resident #1. The previous Executive Director had all the information of the entire investigation. He confirmed the facility should have documented in the clinical record and followed up on the concern when reported to staff and no one did anything. There was no documentation and	A 025		

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A 025	Continued From page 5 no follow through from facility staff. He confirmed the facility did not report to any state agencies. Interview on at 5:15 p.m., the Advanced Practical Registered Nurse (APRN), she said the first time she saw the on Resident #1 was upon admission to the Hospice House, and in her professional opinion it looked like or even , so the team at hospice collectively recorded the as they felt it led to Resident #1's decline/ . **Photographic evidence provided by Hospice nursing staff** Class II .	A 025		
A 165	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	A 165		

Agency for Health Care Administration

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A 165	Continued From page 6 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 Families as required under chapter 415.	A 165		

Agency for Health Care Administration

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A 165	Continued From page 7 (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 1 business day after the incident pursuant to rule	A 165		

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A 165	Continued From page 8 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 review, and staff interviews, the facility failed to file 1 day or 15 day adverse incident reports as required for 1 (Resident #1) of 3 resident records reviewed for adverse incidents. The resident suffered unreported blunt force , was not assessed by the facility nurse after receiving report of the injuries and later found to have expired due to complications of a . The findings included: Review of the Medical Examiner's Report for Resident #1 dated , revealed (a) cause of : complications of , (b) due to: blunt . Review of Nursing Policies & Procedures, manual section: Emergency Care, Policy Name: Unusual Occurrence. Effective date: , "Policy: All unusual instances or occurrences related to the care of the resident will be immediately reported. Procedure 1. Nursing staff will closely monitor and document the behavior and condition of the resident involved to check for any injury and to prevent reoccurrence of the incident. This is to be documented on an Incident Report. 2. The person in charge will notify the following for the residents involved in the incident: a. the attending	A 165		

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A 165	Continued From page 9 physician, b. responsible party, c. Director of Clinical Services." Interview on at 1:15 p.m., the Hope Hospice Nurse said on a routine visit on , was noted on Resident #1's upper going down to the , and she immediately notified the facility's Licensed Practical Nurse (LPN) Staff C. Interview on at 2:10 p.m., the Director of Clinical Services (DCS) said he received no reports from facility staff regarding the on Resident #1. He said the first time he heard about the on Resident #1, was after Resident #1 was transferred to hospice on . He said he was notified by the hospice house supervisor of the on Resident #1, he then went over to the facility to assess Resident #1. He said before being transferred to Hospice House Resident #1 was bedridden and non- . He had not received any reports of Resident #1 having had a ; she lived in the memory care unit and was to have hourly checks by facility staff. The DCS confirmed there is no documentation indicating Resident #1's representative was notified of the . He said an investigation was performed and indicated LPN Staff C and previous LPN Staff G were notified of the by the hospice nurse on and did not input any document in Resident #1's clinical record. He confirmed there was no documentation indicating Resident #1 was being checked on hourly as required by the facility staff, and there is no documentation that Resident #1 was assessed by Staff C and Staff G after receiving reports of the on Resident #1. He confirmed the concern was not reported to any state agencies.	A 165		

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A 165	Continued From page 10 Interview on .. . .. at 2:55 p.m., the Memory Care Director (MCD) said Staff C and Staff G should have assessed, documented and reported to her after receiving report of the ..ـ on Resident #1. She did not receive any reports. She only found out about the ..ـ after Resident #1 was transferred to Hospice House. Interview on .. . .. at 3:55 p.m., LPN Staff C confirmed receiving the report from the Hospice Nurse of . . . . ـ on Resident #1. She did not report to the Director of Memory Care. She did not document in Resident #1's clinical record; nor did she go and assess or observe Resident #1 for the . . . . ـ. Interview on .. . .. at 4:50 p.m., former employee LPN Staff G confirmed the report was given to him about the . . . . ـ on Resident #1 and he did not document in the clinical record, nor did he assess for treatment or observe Resident #1 for the ..ـ. Interview on .. . .. at 5:15 p.m., the Advanced Practical Registered Nurse (APRN), she said the first time she saw the .. . .. on Resident #1 was upon admission to the Hospice House, and in her professional opinion it looked like .. . .. or even . . . . . , so the team at hospice collectively recorded the ..ـ as they felt it led to Resident #1's decline/. . . . **Photographic evidence provided by Hospice nursing staff** Class III `	A 165		