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 |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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<br><br>An unannounced Relicensure with Limited Mental Health (LMH), Complaint (#2021011035, #2021010446, #2021010627, #2021013980) and Generator Monitoring survey was conducted from - at Sheridan Manor Inc. The facility had deficiencies identified related to the Relicensure and Complaint (#2021013980) at the time of the survey. | A 000 | | |
| A 025 | 429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision<br><br>429.26<br>(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.<br><br>59A-36.007 Resident Care Standards.<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal | A 025 | | |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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 1<br><br>supervision as appropriate for each resident, including the following:<br>(a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C.<br>(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.<br>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.<br>(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.<br>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined the facility failed to ensure that residents are adequately supervised while sitting outside on the patio area of the facility, for 1 of 3 sampled residents (Resident #1). As evidenced of Resident # 1 being left outside on for an extensive amount of time, resulting in the resident being transferred to the hospital and suffering from and Heat Exhaustion. The facility also failed to contact a resident's Healthcare Provider when the | A 025 | | |

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 |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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<br><br>resident exhibited significant health changes, for 1 out of 3 sampled resident records reviewed (Resident #1).<br><br>The findings included:<br><br>A review of the facility's policy and procedure titled, "Change in Resident Condition" dated . . . . . revealed the following:<br>I. PURPOSE<br>a. To provide guidelines for situations when there is a change for resident conditions.<br>II. POLICY<br>a. Sheridan Manor will monitor residents for change of condition for must take the actions appropriate actions appropriate actions and to report changes in condition to appropriate parties by federal and state mandates.<br>III. PROCEDURE<br>(1) In case of an accident or sudden adverse change in resident's physical condition or emotional adjustment, the facility will take the actions appropriate to the specific circumstances to address the needs of the resident, including notifying the primary care physician and the representative or legal surrogate, if any. The facility will retain a record of all such accidents of sudden adverse changes and the facility's response in the resident's files.<br><br>Review of the facility online website was conducted on . The website: https://www.seniorhomes.com/Florida/Hollywood/Sheridan-manor-Hollywood shows the following:<br>A. Available Services: Staff are available 24-hours a day to respond to help for request from emergency pull . . . . . in bedrooms and bathrooms. Our Caregivers are there to proactively help with the Activities of Daily Living, (ADL's), such as mobility, grooming, bathing, and | A 025 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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 3<br>medication management.<br>B. Come experience the good life at Sheridan Manor, where are passionate about quality care.<br><br>Review of the preliminary adverse incident report submitted by the facility Administrator on . . . . . at 9:15 PM, revealed the following.<br>On . . , Resident # 1 was found in the courtyard by Staff B (Caregiver), shortly before Lunch, unresponsive in his wheelchair. 911 was called, immediately. While the Staff (Staff B and Staff A) were bringing Resident # 1 inside the facility, Resident slid out of wheelchair onto the pavement. Resident was brought inside with assistance of another CNA on duty (Staff A). Paramedics arrived shortly and Resident was taken to the hospital. Date and time of incident: at 11:49 AM. Notifications listed as the father and Physician notified.<br><br>Review of the facility incident report dated completed by Staff B (Assistant Administator), the following was noted. Resident was unresponsive sitting outside he was extremely hot to the touch. Resident was wheeled in the wheelchair towards the inside. Resident slid to the ground. Staff called 911. Staff B and Staff A noted as employees involved.<br><br>On at 10:30 AM, a tour of the facility was conducted. It was revealed that there is only one Courtyard Patio area, which is located near the main dining room. At the time of the incident on , the courtyard didn't have any shading or coverage to protect the residents seated in the area. During an interview with the Administrator on . . . . . at 9:35 PM, it was revealed that the residents were allowed to sit in the patio area freely prior to the . . . . . incident regarding Resident #1; she also stated | A 025 | | |

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 |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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 4<br><br>that there were no patio sitting restrictions. She stated, since that incident the facility has implemented changes regarding residents sitting in the area.<br><br>On at 11:20 AM, an interview was conducted with the Staff B (Assistant Administrator), the following was revealed. She stated she worked from 7:00 AM - 3:00 PM on the day of the incident. She stated on she saw Resident # 1 after 9:00 AM. She says Staff C, Certified Nursing Assistant (CNA)/Caregiver)brought him out to the dining room for breakfast. She stated she saw him eat his breakfast and he wheeled himself outside to the patio, as he usually does. She stated he seemed to be getting into the normal routine. Staff B, stated at this time, she was cleaning the breakfast dishes and was working with the COVID-19 testing in the facility. She stated she looked at the clock and saw it was 11:00 AM, and that all the residents seemed to be okay. Staff B stated that she started preparing lunch and was running behind.<br><br>During a further interview with Staff B, at this time, she stated she saw Resident # 1 outside through the window of the dining room (near the patio area), and he (Resident#1) didn't appear alert when she saw him outside. She stated, she attempted to bring him (Resident# 1) inside because he was hot. She stated it was hot and he was wearing a sweater. She asked Staff A (CNA/Caregiver) to come over and assist her to bring in Resident # 1 from the outside pavement as he had slid down in the wheelchair. She stated the facility was very short staffed due to the Coronavirus, therefore she was doing multiple tasks on that , day. She stated Staff A came over to assist her to lift him inside the | A 025 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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 5<br><br>facility from the hot pavement. She stated Staff A called 911 on the phone while they were bringing him in to the facility. She says his [redacted] was down, but he was breathing. She stated he was breathing; therefore, he did not require [redacted] ([redacted]). The paramedics came and his temperature was high, (they did not tell her what his temperature was at that time). She stated, he was transported to the local hospital. She stated the hospital Nurse called her for a family contact phone number. The nurse stated the resident was not looking very good. She stated she touched him, and he felt hot to the touch. She stated, she didn't take his temperature when he was readmitted into the facility. She stated, it was always the practice of Resident # 1 to go out to the patio to smoke every day.<br><br>On [redacted] at 11:35 AM, an interview was conducted with the Administrator. She stated she was scheduled to work from 10:00 AM - 2:00 PM on [redacted]. However, she stated she was not present at the facility at the time of the event regarding Resident #1. She stated, Staff B called her hysterical about lunch time around noon. She stated Staff B advised her that Resident # 1 outside on a hot surface. She stated, she told her that she did not perform [redacted], because he was breathing. She stated, Staff B told her that she spoke to the family member of Resident # 1. At this time, the Administrator was questioned, if the facility had a policy regarding Supervision and/or any policy related to providing supervision for the residents within the facility and outside in the patio area. She stated she did not have a policy. However, she stated she has trained all the staff and verbally informed them not to let residents go outside unsupervised and that she has staffing in the building to watch over the residents. At that time of the incident, she had multiple staff out due | A 025 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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 6<br><br>to the various at both of her facilities. And that she was trying to cover both.<br><br>On at 1:35 PM, an interview was conducted with Staff A (CNA/Caregiver), the following was revealed. Staff A stated she works 9:00 AM - 9:00 PM shift at the facility. She stated she was in the kitchen when she was told to call 911. She stated, she called 911 and the Assistant Administrator (Staff B) told her to take him from outside to inside of the dining room. She stated, she did not know how long he had been outside. She stated she knew he was positive with COVID-19. She stated Resident #1 would always sit outside for many hours. He would come inside when it was raining. The resident would come and tell her that he needed to be brought inside, sometimes. She also stated that the facility was short staffed due to the outbreak of the Coronavirus among staff and residents in .<br><br>During an interview with Resident # 2 on at 12:05 PM, the following was revealed. He stated on , he saw Resident # 1 sitting outside in his wheelchair. He stated Resident # 1 was sitting directly in the sun on . He stated Resident # 1 loved to sit outside and smoke every day. He stated this , day, the resident had been sitting outside for several hours. He stated Staff B (Assistant Administrator) walked by the window and saw Resident#1 slumped down in his wheelchair. He stated Resident # 1 didn't look too good. He stated Staff B (Assistant Administrator) ran out and called Staff A (Caregiver), and they helped him up from the pavement, because Resident # 1 had slipped out of the chair onto the pavement. He stated the sun was very hot that day. He says he never recalled any staff coming | A 025 | | |

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 |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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 7<br><br>outside to check on them while they were outside. He stated if anyone wanted water they would have to go inside and get it from the water cooler.<br><br>During an interview with Resident # 5 on at 12:20 PM, it was revealed that Resident #1 would sit outside daily and smoke. He stated, Resident # 1 would go outside and stay for several hours. He stated that there were no bottles of water outside and staff didn't really check on residents while sitting outside. He stated residents are allowed to come and go as they please.<br><br>During an interview with the Detective on at 1 PM, regarding the incident for Resident #1 revealed the following. He stated that the surveillance came showed that the resident wheeled himself outside at approximately 9 AM on and that he remained outside in the area for 3 hours. Shortly after the 3hrs, it is noted that Resident#1's arm goes limp in his wheelchair and slumps down in the chair. Around 12 PM, a Caregiver comes outside and sees the resident slumped in his wheelchair. He stated the Caregiver calls for help from another staff member to get the resident up from the pavement, as he has now slipped out of his wheelchair.<br><br>A review of Resident #1's Health Assessment form (AHCA form 1823) dated revealed the resident suffers from (affecting right side). Resident is noted to be alert and oriented X1. Resident requires supervision with all his Activities of Daily Living (ADLs). Resident is also noted to require daily oversight for observing well-being, observing daily whereabouts and | A 025 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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 8<br>reminders for important tasks.<br><br>A review of Resident's # 1 electronic progress notes revealed the following.<br><br>1) (documented at 1:58 p.m.) -on CNA sent resident to the hospital. She stated he was weak and and unable to use his . 911 was called and resident transferred to [hospital]<br>2) at 3:16 p.m. - documented call placed to the hospital, spoke to nursing station, resident was tested positive for COVID-19 and admitted to the hospital,<br>3) at 4:36 p.m. - received multiple calls from Social Worker/Case Manager advising facility that resident is , , , and they want to send resident to the facility, even though the resident is COVID-19 positive. I advised hospital manager that facility cannot accept COVID positive resident for the safety of other residents and staff. (Written by the Administrator).<br>4) at 1:05 p.m. - received call from Social Worker stating Resident # 1 no longer had signs and symptoms of COVID-19. The Social Worker stated she could no longer hold the resident. The Administrator requested 2 negative COVID-19 tests and the Social Worker advised the Administrator that she could not provide 2 negative tests. The Administrator advised the Social Worker that she would take the resident , but the Social Worker needs to tell Resident # 1 that he must be .<br>5) On at 10:41 PM, Resident # 1 returned to the facility via non-emergency medical transportation. Resident is awake and alert. Paramedics took resident to his room via stretcher. Upon entering resident's room, I greeted resident and resident stated He is happy | A 025 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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 9<br><br>to be . . . home and just wanted to to go to sleep because he couldn't sleep while in the hospital. Vitals taken, . . . . , . . . . . (B/P) 142.72, . . . . , . , . . . 17, . . Saturation 98%, and Temperature 97.7. Resident denies any . . . and chills. He stated he wanted to sleep. Will continue to monitor resident for any changes in resident's condition.<br>6) On . . . . . at 7:08 AM, Resident # 1 up in bedroom being assisted for AM care, (Bed bath) and hair care provided. Resident started coughing and requested a cigarette, but no cigarette was given to resident, due to resident's . . . . Will follow-up with morning staff to notify Doctor's office regarding resident's . . . . .<br>7) On . . . . . at 12:40 PM, Resident returned from hospital last night ( . . . . . ). Resident observed to be feeling better, but it was routine. Before lunch resident has reported from previous shift that he had a . . . . Resident appeared to be getting . . . into his usual routine. Before lunch, resident was seen in courtyard. When approached Resident # 1 was unresponsive breathing irregularly. Resident # 1 felt hot to the touch and while attempting to bring Resident inside. He slid out of wheelchair. I called for help from Staff A, CNA. She was able to quickly call 911. Resident was carried into facility due to safety concerns because the ground was extremely hot. 911 arrived. Resident was still not responding. Care resumed by Paramedics. Resident was taken to nearby local hospital.<br><br>A review of the online website: https://www.accuweather.com was conducted. Accu Weather search was conducted on GOOGLE for the date of . . . . . for the following times:<br>a). . . . . 9:00 AM = 79 degrees Fahrenheit.<br>b). . . . . 10:00 AM = 91 degrees | A 025 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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 10<br><br>Freedmen.<br><br>A review of the hospital records for Resident #1 revealed the following. Resident #1 transferred to the hospital Emergency Department on via emergency transport. The chief complaint was . Resident was found outside today in acute , distress. with temp as high as 110 F degrees. Patient noted to be severely , temperature of 106 . Resident transferred to ; resident expired on at 0351.<br><br>On at 4:00 PM, interviews were conducted with the Administrator, the Consultant and Director of Nursing (DON). The Administrator stated that they had failed to ensure that Resident # 1 remained and until he received a negative COVID-19 test result. The DON stated the physician should have been called immediately by the direct care staff, after documenting a significant change in condition, (i.e., ) in the progress notes. She stated that the direct care staff should have checked on residents sitting outside on the patio and offered them hydration during that period of 3 hours. The Administrator and the DON stated that they should have documented their internal investigation and completed the 1-day and 15-day adverse incident reports.<br><br>On at 3:00 PM, an exit conference was conducted with the Administrator and the DON. The findings were acknowledged.<br><br>Class II | A 025 | | |
| A 165 | 429.23( & ) FS Risk Mgmt & QA | A 165 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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 165 | Continued From page 11<br><br>429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.-<br>(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.<br>(2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means:<br>(a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in:<br>1. ;<br>2. or damage;<br>3. Permanent ;<br>4. or of bones or joints;<br>5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;<br>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<br>7. An event that is reported to law enforcement or its personnel for investigation; or<br>(b) Resident elopement, if the elopement places the resident at risk of harm or injury.<br>(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 | A 165 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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 165 | Continued From page 12 | A 165 | | |

preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.
(4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.
(6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or 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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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 165 | Continued From page 13<br><br>this fact to such regulatory board.<br>(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.<br>(10) The agency may adopt rules necessary to administer this section.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interview and record review, it was determined that the facility failed to complete and submit the initial 1-day and submit a full 15-day adverse incident report for an incident involving a resident being left in the sun for 3-hours and experiencing heat exhaustion and resident being transferred to the critical care unit of the hospital, as a result, for 1 of 3 sampled resident records reviewed (Resident # 1).<br><br>The findings included:<br><br>Review of the preliminary adverse incident (1-day report) report submitted by the facility Administrator on at 9:15 PM, revealed the following. On , Resident # 1 was found in the courtyard by Staff B (Caregiver), shortly before Lunch, unresponsive in his wheelchair. 911 was called, immediately. While the Staff (Staff B and Staff A) were bringing Resident # 1 inside the facility. Resident slid out of wheelchair onto the pavement. Resident was brought inside with assistance of another CNA on duty (Staff A). Paramedics arrived shortly and Resident was taken to the hospital. Date and time of incident: at 11:49 AM. Notifications listed as the father and Physician notified. | 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 |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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 165 | Continued From page 14<br><br>Review of the facility incident report dated completed by Staff B (Assistant Administator), the following was noted. Resident was unresponsive sitting outside he was extremely hot to the touch. Resident was wheeled in the wheelchair towards the inside. Resident slid to the ground. Staff called 911. Staff B and Staff A noted as employees involved.<br><br>A review of Resident #1's Health Assessment form (AHCA form 1823) dated revealed the resident suffers from (affecting right side). Resident is noted to be alert and oriented X1. Resident requires supervision with all his Activities of Daily Living (ADLs). Resident is also noted to require daily oversight for observing well-being, observing daily whereabouts and reminders for important tasks.<br><br>A review of the hospital records for Resident #1 revealed the following. Resident #1 transferred to the hospital Emergency Department on via emergency transport. The chief complaint was . Resident was found outside today in acute distress. with temp as high as 110 F degrees. Patient noted to be severely temperature of 106 . Resident transferred to ; resident expired on at 0351.<br><br>On at 11:35 AM, an interview was conducted with the Administrator. She was asked to provide the 1-day and 15-day adverse incident report. She stated that she submitted the 1-day adverse incident report, but later withdrew it because the Law Enforcement Detective told her that they had dropped the criminal charges | A 165 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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 165 | Continued From page 15<br><br>against the facility. She stated she didn't know if she needed to complete the 15-day adverse incident report. She stated she did not have any written documentation regarding the incident involving Resident # 1.<br><br>On [redacted] at 4:00 PM, an interview was conducted with the Administrator. She acknowledged the findings.<br><br>Class III | A 165 | | |
| CZ814 | 435.12(2)(b-d), FS Background Screening Clearinghouse<br><br>435.12 Care Provider Background Screening Clearinghouse.-<br>(2)(b) Until such time as the [redacted] are enrolled in the national retained print [redacted] notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency.<br>(c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days.<br>(d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [redacted] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social | CZ814 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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 |
|---|---|---|---|---|
| CZ814 | Continued From page 16<br><br>security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure that all employees who were terminated were updated with a termination date in the Agency for Healthcare Administration, (AHCA), Background Screening Clearing House Roster within 10-days of termination for 4 of 12 sampled employee personnel records reviewed: (Staff E, F, G and Staff H).<br><br>The findings included:<br><br>On a review of the online AHCA Background Screening Clearing House was conducted. It was revealed that Staff E, F, G and H were listed on the Background Screening Clearing House Roster without a termination date.<br><br>A side-by-side review of the employee personnel records was conducted with the Administrator. The following hire dates were confirmed based on the AHCA Background Screening Clearing House:<br>1. Staff E, Certified Nursing Assistant, was hired on .<br>2. Staff F, Home Health Aide, (HHA), was hired on .<br>3. Staff G, Certified Nursing Assistant, was hired on .<br>4. Staff H, Dietary Aide was hired on /20211. (Photographic evidence).<br><br>On a review of the facility direct care | CZ814 | | |

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 |
|---|---|---|---|
| | AL11964562 | A. BUILDING: _____ B. WING _____ | 10/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 2415 NORTH 20TH AVENUE HOLLYWOOD, FL 33020 |

| (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 |
|---|---|---|---|---|
| CZ814 | Continued From page 17<br><br>staffing schedule was conducted for the week of - . It was revealed that Staff E, F, G and H were missing. (Photographic evidence)<br>At this time, the Administrator stated the following:<br>1. Staff E was terminated on .<br>2. Staff F was terminated on .<br>3. Staff G was terminated at least 30 days ago, (exact termination date unknown).<br>4. Staff H was terminated on .<br><br>On at 12:15 PM an interview was conducted with the Administrator. She acknowledged the findings.<br><br>Unclassified | CZ814 | | |