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
	AL11969594	A. BUILDING: _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND LIVING AT LAKEWOOD RANCH	7230 UNIVERSITY PARKWAY SARASOTA, FL 34240

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A 000	Initial Comments An unannounced complaint survey for #2022001432 and 2022002916 was completed on through at Grand Living at Lakewood Ranch, an assisted living facility in Sarasota, Florida. The following is a description of the deficiency. .	A 000		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline,	A 030		

AHCA Form 3020-0001

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

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A 030	Continued From page 1 1(800)96- . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which	A 030		

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A 030	Continued From page 2 residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's	A 030		

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A 030	Continued From page 3 representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care . , , ..., and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally . . , ..., the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal	A 030		

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A 030	Continued From page 4	A 030		

representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.
(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that

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A 030	Continued From page 5 retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . , . . . or . . , ... under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review, and staff interviews, the facility failed to ensure each resident's advanced directives were honored for 2 (Residents # 2 and #3) of 3 residents reviewed; and failed to ensure a safe environment for 1 (Resident #1) of 3 residents reviewed. Failure to honor resident rights to have , , . . .	A 030		

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A 030	Continued From page 6 ( ) prevents any chance of saving a resident who had suffered a event. Failure to maintain a safe environment with unsecured bed rails has the potential for a resident to become trapped and could lead to suffocation and ..... The findings included: A review of the Wellness Standard [ ] Policy dated documented, "Policy: This community provides each Resident or Resident's representative with information regarding Health Care Advanced Directives and will honor the Resident's Choices." Under "Procedure 2. This community will honor all Health Care Advanced Directives, including for the Resident. If none are provided, then , , will be preformed." The policy did not include a protocol for nurses to declare residents and not perform rather than honoring the resident's preference for . 1. Record Review revealed a progress note dated at 12:39 p.m., "Nursing called to resident room by housekeeping at approx. 1055 am resident found on floor with robe on, next to toilet. DOHW [Director of Health and Wellness] called to room and arrived approx. 11:00. Resident mottled and . Two nurse verification of resident time of 1105. Sheriff department called to report unexpected . Srgt. called to report that they do not respond to unexpected deaths in nursing homes. Medical examiner (ME) called. ME [name] reported to notify funeral home and no need for further investigation. [Resident's daughter] called by DOHW and [Director of Marketing] to alert family of . Family	A 030		

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A 030	Continued From page 7 appreciative of call and reports, "My mom is happy with dad." ... Resident cleaned and placed in bed x 4 assist." Signed by DOHW. Interview on [illegible] at 4:40 p.m., Licensed Practical Nurse (LPN) Staff B said Resident #2 did not like to come out of her apartment much. She could get up and ambulate, but had some [illegible]. She could get herself up, but needed help with [illegible]. She was last seen by the med tech that morning at 8:48 a.m. LPN Staff B said they were called out of morning meeting at 10:45 a.m. When she and Med Tech Staff C got up to the resident's room, housekeeping was there. After she and Staff C arrived the DOHW arrived next and then the Director of Marketing arrived. They saw Resident #2 on the floor by the toilet. She was dressed in a nightgown with her brief down. She was blue and had some purpling on her skin [lower extremities]. Her [illegible] was pale with a [illegible] on her forehead with dried [illegible]. She had a chocolate like substance coming from her [illegible] and feces on her bottom. They turned her over and she had no [illegible] rate. The DOHW was on the phone with the family and came [illegible] and said they were not going to initiate [illegible]. Resident #2 did not have a [illegible] and [illegible] was not attempted. LPN Staff B said, typically, if someone does not have a [illegible], you do [illegible]. She said she and the med tech talked about starting [illegible]. They moved and turned her over and DOHW said not to do [illegible]. Then they cleaned her up, changed her nightgown and put her into bed. [illegible] was not called. Interview on [illegible] at 11:10 a.m., Med Tech Staff C said Resident #2 was ok that morning when she gave her medications. There were no signs or symptoms and the resident did not say	A 030		

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A 030	Continued From page 8 anything about being ill. Med Tech Staff C said she and the nurse walked in and saw the resident on the bathroom floor between the toilet and sink areas. She looked pale, and had fluid coming out of her . She was noted to have moved her ; and had a on her forehead with dried . The resident had on a brief and night gown. The brief was down around the lower part of her . The gown was mid-length and was was pulled up around her waist area. She said they called the supervisor immediately - turned her over and began to clean her up. The registered nurse (RN) DOHW must have checked the status. She verified they did not perform . She said she did what the DOHW told her to do. Med Tech Staff C verified they are supposed to check to see if they have a ; the status; and then perform . She said they followed the directions of the supervisor to assist cleaning her up and then to move to bed. She was not told to do . Interview on at 11:00 a.m., the DOHW said she had gone to the room when Resident #2 was found. She said she was on the phone with the daughter who is the POA. The daughter did not want done to the mother. The daughter said her mother was happy now as she was with her husband who had years earlier. When asked about a , the DOHW verified the resident did not have a . The DOHW said she was blue and mottling in lower extremities and she and the LPN pronounced the resident . They did not do . 2. Record review of Resident #3's record included a nurse's note dated at 17:08 p.m. documenting, "At approx. 0945 health and wellness assistant called this writer into room	A 030		

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A 030	Continued From page 9 stating resident "was ." Upon entering room, resident laying down, to touch, stiffness in upper extremities. No felt, no breath visualized or heard. Auscultated for 1 minute without breath sounds/apical . Called RN supervisor and Director of Health and Wellness into room for assistance. Dialed 911. Followed instructions from dispatch. Upon arrival, resident pronounced at 0945. Family notified by health and wellness director. Funeral home came to pick up resident at approx. 1530. Signed by a nurse." There is no documentation to show was initiated. Interview on at 2:02 p.m., the housekeeper who found Resident #3 verified she had found her in her apartment on the floor, She verified she was not breathing and called the housekeeping supervisor who called the nurse. Nursing staff was at desk and they came and checked her out. She said the resident was down not breathing and had "left her." Interview on at 1:34 p.m., the Administrator said she did not know how long Resident #3 had been before she was found. She verified the RN who found her pronounced the and called . She verified the resident was last seen the evening before at supper. 3. Interview on at 8:54 p.m., caregiver Staff E said she went to do the 2-hour check and found him in the same position he usually was " down, sleeping on his . She said the side rail was on the bed and he was wedged on top, and was to the side of siderail. down like hanging off the bed. Body still on the middle of the bed. had pooled on the floor from where he hit his . She said she tried to	A 030		

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A 030	Continued From page 10 fix his position and was unable to move him up. The second caregiver had gone upstairs to give food to her sister. So she went to get help from the other girls. The second caregiver called the nurse. On [redacted] at 10:15 p.m., LPN Staff A said she got a call and went to Resident #1's room on after 4:30 a.m. She said when she got there 2 caregivers were in the room. She said Resident #1 was [redacted] down between the side of the bed and the rail. His was wedged beside the rail against his left check, and his body was trapped by the rail. Photographic evidence showed the resident slumped on his [redacted] over a pillow, with his left wedged by the bedrail to between the bed and the rail. His [redacted] was to the side of the rail which was wedged into his left cheek. had pooled on the floor under where the resident's hung down. The bedrail was an arch type which had bars that slide under the mattress. The bar had an 8 to 9 inch gap between the sides of the rail. ** Photographic Evidence on File** 4. On at 11:30 a.m., a tour of 9 resident rooms, in which the resident's utilized bedrails, was completed. was observed to have a [redacted] bed rail located at the [redacted] of the bed, with the upper rail gapped 5 inches from the bed. The lower section wedged tight into the mattress. The bedrail had come unanchored from the bed and forced a 5 inch gap at the top. At that time the resident said the bedrail had been that way for a while and maintenance had not fixed it. The resident said the rail was needed to be able to independently get into and out of bed.	A 030		

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