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
	AL11969827	A. BUILDING: _____ B. WING _____	03/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR LIVING	5650 GANTT RD SARASOTA, FL 34233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint survey for complaint #2021012638, #2021016465 with an initial extended congregate care (ECC) survey was conducted [redacted] at [redacted] Senior Living, an assisted living facility in Sarasota, Florida. Complaint #2021012638 was not substantiated. Complaint #2021016465 was substantiated at A0025 and A0030. 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 Resident Care Standards. An assisted living facility must provide care and	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 services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 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 interviews and record reviews, the facility failed to provide one (Resident #1) of three residents with the appropriate care and services needed after she obtained a . The findings included: 1. A review of the "Resident Incident Report"	A 025		

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A 025	Continued From page 2 dated showed Resident #1 had a at 4:30 a.m. Resident #1 called her daughter to tell her she . The daughter called the facility to notify them of her . When staff entered Resident #1's room she was in bed and complained of "discomfort." The staff was instructed by her daughter and son not to send her to the emergency room but to give her , . . The next morning the granddaughter came to the facility. She and the director of nursing went to assess Resident #1. Resident #1 verbalized feeling stiffness and was sent to the hospital. A review of the hospital records showed she had an , of her , showing "A non-displaced through the base of the odontoid is present (type III odontoid). The lines extend across the lateral of C2 on each side without definite extension of the foramen transversaria." A review of Resident #1's "Resident Information/Emergency Contact Sheet" showed her niece is the first person to contact in an emergency. The niece is the 'legally responsible party'. On at 1:15 p.m., an interview was conducted with Resident #1's niece. She said she is the granddaughter and not the niece of Resident #1. She said she was not called by the facility concerning this . Resident #1's son (her father) called her to tell her about this . She went to the facility the same morning and talked with the Director of Nursing (DON). The granddaughter said the DON did not know about this and they both went to Resident #1's room. When they saw Resident #1 in her room, the resident said she is still in , . Resident #1 said she told the staff (at the time of the) she	A 025		

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A 025	Continued From page 3 wanted to go to the hospital but they wouldn't send her. At that time the granddaughter requested for Resident #1 to be sent to the hospital. On at 12:46 p.m., in an interview care giver Staff A said Resident #1's daughter called her on the phone and told her Resident #1 had a . When she went to Resident #1's room the resident was talking on the phone with her son. Both the daughter and son of Resident #1 told her not to send Resident #1 to the hospital but to give her , . . . Resident #1 told Staff A she wanted to go to the hospital. She knew Resident #1's son and daughter were not her health care surrogate but did not know what else to do. On at 1:00 p.m., in an interview former DON Staff B said she did not know about this until the next morning when Resident #1's granddaughter came into the facility. They both went to Resident #1's room to evaluate her. She was told by the care givers (Staff A was one of them) they talked to Resident #1's son and daughter and they both declined to send Resident #1 to the hospital. At that time they were told by the DON to call the emergency person documented in the resident file. Staff B confirmed the staff did not notify Resident #1's responsible person when she had a . 2. Further review of Resident #1's closed record showed there was no documentation she received , for her , . There was no documentation showing Resident #1 received any type of monitoring, assessment, evaluation after her . Review of Resident #1's closed record showed on at 12:19 p.m., the DON documented Resident #1 had a at 4:30 a.m. When the DON checked on Resident #1 she	A 025		

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A 025	Continued From page 4 complained of hitting her . . . when she . and of a "very stiff ." She was then sent to the hospital. The facility failed to provide Resident #1 with the appropriate care and services needed after she , failed to send Resident #1 to the hospital when she requested to go, and failed to notify her responsible party of this . . Class II	A 025		
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,	A 030		

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A 030	Continued From page 5 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 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),	A 030		

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A 030	Continued From page 6 F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which 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 [redacted] 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,	A 030		

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A 030	Continued From page 7 autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's 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	A 030		

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A 030	Continued From page 8 relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal 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	A 030		

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A 030	Continued From page 9 and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that 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 interviews, the facility violated the rights of one (Resident #1) of three residents by not following her request to go to the hospital and not notifying her responsible	A 030		

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A 030	Continued From page 10 party when she had a with injuries. The findings included: 1. A review of the "Resident Incident Report" dated showed Resident #1 had a at 4:30 a.m. Resident #1 call her daughter to tell her she . The daughter called the facility to notify them of her . When staff entered Resident #1's room she was in bed and complained of "discomfort." The staff was instructed by her daughter and son not to send her to the emergency room but to give her . A review of Resident #1's "Resident Information/Emergency Contact Sheet" showed her niece is the first person to contact in an emergency. She is the 'legally responsible party'. An interview was conducted with Resident #1's niece on at 1:15 p.m. She said she is the granddaughter and not the niece of Resident #1. The granddaughter said she was not called by the facility concerning this . Resident #1's son (her father) called her to tell her about the . She went to the facility the same morning and talked with the Director of Nursing (DON). The granddaughter said the DON did not know about this and they both went to Resident #1's room. When they saw Resident #1 in her room, the resident said she is still in . Resident #1 said she told the staff (at the time of the) she wanted to go to the hospital but they wouldn't send her. At that time the granddaughter requested for Resident #1 to be sent to the hospital. On at 12:46 p.m. in an interview care giver Staff A said Resident #1's daughter called her on the phone and told her Resident #1 had a	A 030		

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A 030	Continued From page 11 . When she went to Resident #1's room, the resident was talking on the phone with her son. Both the daughter and son of Resident #1 told her not to send Resident #1 to the hospital but to give her , . . . Resident #1 told Staff A she wanted to go to the hospital. She knew Resident #1's son and daughter were not her health care surrogate but did not know what else to do. On at 1:00 p.m. in an interview former DON Staff B said she did not know about this until the next morning when Resident #1's granddaughter came into the facility. They both went to Resident #1's room to evaluate her. She was told by the care givers (Staff A was one of them) they talked to Resident #1's son and daughter and they both declined to send Resident #1 to the hospital. At that time they were told by the DON to call the emergency person documented in the resident file. Staff B confirmed the staff did not notify Resident #1's responsible person when she had a . Class III	A 030		
AE208	59A-36.021(8) FAC 429.07(3)(b)3, FS ECC - Records 59A-36.021(8) RECORDS. (8) RECORDS. In addition to the records required in rule 59A-36.015, F.A.C., a facility providing extended congregate care services must maintain the following: (a) The service plans for each resident receiving extended congregate care services; (b) The nursing progress notes for each resident receiving nursing services from the facility's staff; (c) Nursing assessments; and, (d) The facility's extended congregate care	AE208		

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AE208	Continued From page 12 policies and procedures. 429.07 (3)(b), FS 3. A facility that is licensed to provide extended congregate care services shall maintain a written progress report on each person who receives such nursing services from the facility's staff which describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse, or appropriate designee, representing the agency shall visit the facility at least twice a year to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with this part, part II of chapter 408, and relevant rules. One of the visits may be in conjunction with the regular survey. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall serve as part of the team that inspects the facility. The agency may waive one of the required yearly monitoring visits for a facility that has: a. Held an extended congregate care license for at least 24 months; b. No class I or class II violations and no uncorrected class III violations; and c. No ombudsman council complaints that resulted in a citation for licensure. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure one (Resident #4) of one resident received a service plan and progress notes while receiving Extended Congregate Care (ECC) services.	AE208		

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(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
AE208	Continued From page 13 The findings included: 1. A review of the facility's ECC log showed on Resident #4 started receiving ECC services. A review of the ECC book and Resident #4's closed record showed there was no ECC service plan. Further review of the ECC book and Resident #4's closed record showed there were no progress notes showing he received ECC services. His record showed he stopped receiving ECC services on . On at 11:00 a.m. in an interview the Executive Director said Resident #4 required total care with his activities of daily living (ADLs). The staff had to help him with his ADLs. She reviewed the ECC book and Resident #4's closed record and confirmed there was no ECC service plan or progress notes available. Class III	AE208		
AE210	59A-36.011(8) FAC ECC - Training (8) EXTENDED CONGREGATE CARE (ECC) TRAINING. (a) The administrator and ECC supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months of beginning employment in a currently licensed ECC facility as an administrator or ECC supervisor. Successful completion of the assisted living facility core training shall be a prerequisite for this training. ECC supervisors who attended the assisted living facility core training prior to , , , shall not be required to take the	AE210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969827	A. BUILDING: _____ B. WING _____	03/14/2022

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AE210	Continued From page 14 assisted living facility core training competency test. (b) The administrator and the ECC supervisor, if different from the administrator, must complete a minimum of 4 hours of continuing education every two years in topics relating to the physical, [illegible], or social needs of frail elderly and persons, or persons with 's or related . (c) All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule requirements, and the delivery of personal care and supportive services in an ECC facility. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure one (Executive Director) of four personnel records reviewed is trained in extended congregate care (ECC) regulations. The findings included: 1. An interview was conducted with the executive director on at 11:00 a.m. She said she does not have the required four hours of training. There is no documentation of her training. Class III	AE210		