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
	AL11911452	A. BUILDING: _____ B. WING _____	04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN CITY SENIOR LIVING	3855 UPPER CREEK DRIVE RUSKIN, FL 33573

(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 A complaint investigation (#2022006098) was conducted at Sun City Senior Living on and . Deficiencies were identified at the time of the visit.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to provide personal supervision and oversight required for each resident, to include awareness of general health, safety, and well-being for 1 (Resident #1) of 85 residents. During the time that Resident #1's elopement was missing and unaccounted for he had a hospitalization and subsequent . . . surgery before the facility was aware of his whereabouts. The lack of resident supervision and both development and implementation of policies and procedures for non-elopement risk residents placed 64 non-elopement risk residents at	A 025		

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A 025	Continued From page 2 immediate risk for harm. Findings Included: A record review of the internal incident report was conducted on revealed Resident #1 was found at a local hotel on at approximately 6:00am by a hotel staff member. The staff notified Emergency Medical Services ( ) when they noticed Resident #1 was having difficulty walking. transported Resident #1 to local hospital A. On at unknown time Resident #1 was then transported from a local hospital A to local hospital B where he agreed to receive evaluation and subsequently underwent surgery for a frontal meningioma on . Further record review of the internal incident report conducted on revealed that on at 3:10pm, facility Staff H began looking for Resident #1 to attend an activity in the facility, but he was not in his room and the bed was nicely made. On at 3:20 pm, the Activity Director called Resident #1's daughter, to ask if Resident #1 was with her or if she knew of anyone that may have signed him out. The daughter reported that he was not with her and was unaware of anyone signing him out. The Executive Director called 911 to report a possible missing resident (#1) on at 3:38 pm. The Executive Director called a local hospital to ask if they had anyone there that was an unidentified patient as they were looking for a Resident. The nurse reported that there was no John or Jane Doe that was in the emergency room. On at 4:46 p.m. the County's Sherriff's Department notified Executive Director that they located Resident #1 at a local hospital. Resident #1's medication observation record	A 025		

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A 025	Continued From page 3 continued to be filled in as if he had been receiving his Ensure as ordered for the time the resident was missing from the facility. It is unknown exactly how long the resident had been missing from the facility prior to the staff at the local hotel finding him. Hospital record review for Resident #1 conducted on [redacted] revealed the following: *Resident #1 was met by [redacted] on site at the local hotel on [redacted] at 10:49am. *Staff at a local hotel stated Resident #1 was sitting outside around 6:00am on [redacted], that he tried to get up and walk a few times but would sit [redacted] down and appeared to be struggling, so they called 911. *Resident #1 reported that he had gone to a local restaurant and stopped at a local hotel to rest. Results of a Computerized [redacted] (CT) of the [redacted] without contrast dated [redacted] at 12:31pm revealed a 5-centimeter [redacted] falcine frontal meningioma with local [redacted] effect and extensive vasogenic [redacted]. A neurosurgical consultation and [redacted] ([redacted]) with contrast were advised. *Resident #1 was transferred to another affiliated local hospital for a meningioma. A review conducted on [redacted] of the definition of a meningioma by the Mayo Clinic, located online with a revision date of [redacted] at https://www.mayoclinic.org/[redacted]-conditions/meningioma/symptoms-causes/syc-20355643 stated "A meningioma is a [redacted] that arises from the meninges - the [redacted] that surround the [redacted] and [redacted] cord. Although not technically a [redacted], it is included in this category because it may compress or squeeze the	A 025		

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A 025	Continued From page 4 adjacent . . , ... and . . . . . . Meningioma is the most common type of that forms in the . . . . Most meningiomas grow very slowly, often over many years without causing symptoms. But sometimes, their effects on nearby tissue, or may cause serious . . . . . , Signs and symptoms of a meningioma typically begin gradually and may be very subtle at first. Depending on where in the or, rarely, , the is situated, signs and symptoms may include: changes in vision, such as seeing double or blurriness, , especially those that are worse in the morning, hearing loss or ringing in the , memory loss, loss of smell, ... , ... in arms or , or language difficulty." A record review for Resident #1 conducted on the Agency for Healthcare Administration (AHCA) 1823 health assessment dated listed and . . . . with a history of . . . . . He was not an elopement risk. He was independent with all activities of daily living. The . . . sheet listed a date of admission of . The Physician Progress note dated . . . . . revealed to continue with precautions and prevention due to increased risk for due to , . . , and decreased sensation. The diagnosis/assessment was listed as . . . . , unsteady gait, , , ... , ... and refusal of care by resident. The facility progress note dated . . . . . noted resident was unsteady on his and refused to use a walker to ambulate. Additionally, it said "will contact primary care physician for , , , , orders if resident allows." The facility's progress note dated revealed Resident #1 lost ,	A 025		

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A 025	Continued From page 5 since move in, new order received for Boost/Ensure by twice a day. A review of the facility Elopement policy entitled "Clinical 19-Elopement" dated , conducted policy said, "elopement precautions are carried out for residents who have demonstrated previous attempts to elope or have a history of elopement."; A review of the policy entitled "Sun City's Elopement Policy" revealed a protocol and steps to take for missing residents. As soon as a resident is found missing to notify the Executive Director and Resident Service Director. All employees are to stop what they are doing and follow the below steps: *Verify if the resident has been signed out at the front desk and check the meal attendance log. *Front desk is to print sheet and provide to all staff and to remain at the front desk to answer calls and monitor other residents. *Assisted living nursing staff are to verify all rooms downstairs (common areas, bathrooms, current resident rooms, closets, stairway, offices, and dining room.) *Memory care nursing staff are to verify all rooms downstairs (common areas, bathrooms, current resident rooms, closets, stairway, offices, and dining room in memory care.) *Dietary staff are to verify the grounds of the community (lake, front entrance, outside patio, of the community near the dumpsters, the empty field, all cars and the bridge.) *Housekeeping and maintenance are to search all of the upstairs (common areas, bathrooms, current resident rooms, closets, stairway, offices and dining room.) *Managers are to search the surrounding areas (nearby stores, nearby communities and roads.)	A 025		

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A 025	Continued From page 6 *If the resident is found, please notify the front desk and the front desk will notify the Executive Director. *Once the protocol above has been followed, they are to meet at the front desk with the Executive Director. *If the resident was located, all staff will sign the elopement form and resume their duties. *If a resident is not found, the Executive Director will contact the local Sheriff's Office and follow the protocol. An attempted record review of the facility's Elopement Policy for non-elopement risk residents conducted on [redacted] at 3:47pm revealed there was no policy and protocols for independent residents. A record review of the facility's elopement drills conducted on [redacted] revealed there were no elopement drills conducted prior to the incident or even after the incident. A record review conducted on [redacted] revealed that all direct care staff had not been trained on meal attendance logs, elopement policies and procedures, daily rounds, or medications passes. A review of the resident sign-out log conducted on [redacted] revealed that Resident #1 had not signed out of the facility between [redacted] and [redacted]. An interview with Staff B conducted on [redacted] at 11:30am revealed that Resident #1 left the building and was gone a few days before anyone knew he was at the hospital. An interview with Staff C conducted on	A 025		

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A 025	Continued From page 7 . . . . . at 11:45am revealed that the facility had elopement training and drills at least once a year, "but the last one was a while ago. They had a meeting about a week after the incident, but I was out of town. I believe they may have talked about elopement." An interview with Staff D conducted on . . . . . at 11:55am revealed that the facility had given elopement training after the incident and "said to be careful and make sure we do check every two hours." She further revealed that the list of residents on the sheet entitled "2-hour check 500 Med-Tech" dated needed updated, but that "the . . . . nurse was busy, so I handwrote in one of the new admission names (Resident #12), crossed off the discharged resident, and still had another resident to add to the list (Resident #13.)" An interview with the Wellness Director conducted on at 12:28pm revealed the facility had a recent resident elopement and that medication technicians signed out Ensure supplements as given to Resident #1 for three days while he was out of the facility. She agreed the resident 2 -hour checklist was not updated on with Resident #12 and Resident #13's names and said, "I try to update the list before they move in, but it depends on how much I have to do during the day." Additionally, she agreed the staff had no idea where Resident #1 was for three days. She said an elopement drill was done on by the Executive Director. She said Resident #1 was alert and oriented and did his own personal care, so they did not check on him. An interview with the Receptionist conducted on at 12:36pm revealed that residents	A 025		

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A 025	Continued From page 8	A 025		

that leave the property are to sign out and she would remind them to sign out and make sure they were just sitting on the porch if they didn't sign out. She said she was not working when Resident #1 eloped.

An interview with the Executive Director conducted on at 3:47pm revealed Resident #1 was gone "a couple of days." He said he interviewed staff about Resident #1, and some were afraid to say they had not seen him but agreed no one noticed he was gone. He said that there were no elopement drills since he started in . The Executive Director stated the staff check on the residents who do not want to be bothered "at least once a day." He said "we checked on him once a day for sure (Resident #1). He confirmed there had not been any additional trainings just discussions at this point for staff.

An interview with the Activities Director conducted on ..... at 3:57pm, she stated the last time she saw Resident #1 was on at the facility's Strawberry Festival.

A review of Resident #1's Medication Observation Record (MOR) conducted on for ....., ... and ..... revealed the initials for Staff G at 8:00am and 5:00pm on each day for ordered Ensure supplement. The initials for Staff E for 8:00am for ordered Ensure supplement on ..... indicating the supplements were given to the resident.

A review conducted on ..... of employee memorandums dated signed by the Wellness Director revealed:

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A 025	Continued From page 9 *Staff G signed out ordered Ensure supplements on until when Resident #1 never received it and had eloped from the facility. *Staff E signed out ordered Ensure supplements on when Resident #1 never received it and had eloped from the facility. An interview with Resident #2 conducted on at 4:19pm she said it had been a month since she last saw Resident #1, and thought he was in the hospital. She said he would come late for breakfast, and she did not think he attended activities. She said he worried her because he would sway when he walked and reach out to hold onto the walls to balance. An interview was conducted on at 4:23pm with Resident #3, who was Resident #1's tablemate for meals. He stated it had been a long time since he had seen Resident #1. An interview with Staff F conducted on at 4:27pm said that Resident #1 had fecal in the dining room at the end of , went outside and in through the kitchen. She said he was not acting like himself that day but did not say if it was reported to anyone. An interview with the Executive Director conducted on at 4:00pm said there were no progress notes between and for Resident #1 because Resident #1 did not have any changes, so they did not document anything.	A 025		

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A 025	Continued From page 10 An interview with the Wellness Director conducted on at 4:50pm she said Resident #1 would sometimes be unsteady and reach out to hold onto the walls or rails and denied hearing about any issues. An interview with Staff E conducted on at 11:00am she said that last year when she started was the only elopement drill the facility had. She said Resident #1 did not like to be checked on and would start yelling, so they would wait for him to come down to meals. She said he would come down in the middle of breakfast and lunch, so the kitchen would save him a plate. She said that signing off as giving an Ensure supplement on at 8:00am was an error on her part, because she had not seen the resident that morning. An interview with Staff G conducted on at 11:00am said "I don't really recall a recent elopement training and not this month, but we did have some before Covid hit." She said it was an error signing off on the Ensure supplements for to because she did not give them. An interview with Staff H conducted on at 11:48am revealed the staff were trained in , of 2022 on elopements and what they should be doing, but no elopement drill was done. She said she was off for two days at the beginning of , , but when she returned on she looked for Resident #1 and could not find him, so she alerted staff who began looking for him. An interview with Staff J conducted on at 12:08pm she said she started working at the facility on and had not	A 025		

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A 025	Continued From page 11 yet participated in an elopement drill. She said they probably had elopement training before she started, and she had not heard anything about a resident eloping. Photographic Evidence Obtained. Class I	A 025		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course.	A 081		

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A 081	Continued From page 12 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in [illegible] control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its [illegible] control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to [illegible] borne [illegible], may be used to meet this requirement. (b) Staff who provide direct care to residents	A 081		

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A 081	Continued From page 13 must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , ... The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an	A 081		

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
	AL11911452	A. BUILDING: _____ B. WING _____	04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN CITY SENIOR LIVING	3855 UPPER CREEK DRIVE RUSKIN, FL 33573

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A 081	Continued From page 14 understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to have proof of required elopement training in the employee files for two (Staff E and Staff F) of three sampled employees. Findings Included: A record review for Staff E conducted on revealed a hire date of and no evidence of elopement response training. A record review for Staff F conducted on revealed a hire date of and no evidence of elopement response training. An interview with the Administrator conducted on at 1:58pm he agreed there was no elopement training in either Staff E or Staff F's files. Class III	A 081		