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
	AL11932484	A. BUILDING: _____ B. WING _____	05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYOU GARDENS	2275 NEBRASKA AVENUE PALM HARBOR, FL 34683

(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 (complaint number 2022006151) in conjunction with a generator monitoring survey was conducted at Bayou Gardens on to . . . . . Deficiencies were identified at the time of survey.	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	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 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 observation, record review, and interviews, the facility failed to provide the personal supervision and oversight required for each resident, to include awareness of general health, safety, and well-being for 1 (Resident #1) of 32 residents. The lack of oversight and notification to appropriate medical staff for a resident with a significant change in condition, subsequent unwitnessed , and post incident follow up care for Resident #1 led to an emergency , to relieve pressure in his from a . Unlicensed caregivers are left to make medical	A 025		

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A 025	Continued From page 2 decisions for the post-incident residents, placing all 32 residents at immediate risk for harm. Findings Included: A review of the facility's incident report completed on conducted on revealed Resident #1 was observed in a curled up sleeping position on the bathroom floor on at around 2am. Staff B and Staff C checked Resident #1 for signs of visual injury. Resident #1 was then helped to bed. Staff C checked on Resident #1 again during 6am rounds she did not try to get Resident #1 out of bed. Around 8:30am Staff A went into Resident #1's room to bring his medication and tried to wake him. Per AIRS report Resident #1 said "No". Around 9am Resident #1's private caregiver arrived at facility and could not wake Resident#1 up. Resident #1's wife was notified by the private caregiver and was called at an unknown time. Resident #1 left the facility on on a stretcher at around 10am. In a review of the facility's surveillance video conducted on at 3:45pm in the Administrator's office revealed a one-hour time discrepancy between the incident time reported and the time on the video surveillance. *On at 12:32pm Resident #1 was observed sitting on the front porch with his private duty caregiver/companion and was seen moving his arms and dancing in his seat while the companion appeared to videotape him on her cell phone. *On at 6:47pm Resident #1 was observed walking independently without holding onto anything to the outside patio and sitting in a chair.	A 025		

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A 025	Continued From page 3 *On [redacted] at 7:15pm Resident #1 was observed being assisted to walk with his arm around a family member's [redacted] coming in from the patio and had difficulty transferring to the chair in the common area. The Administrator was present, and Staff E was observed assisting the family member with Resident #1 down the hallway. *On [redacted] at 12:53am Resident #1's roommate was observed talking with Staff C in the hallway before she entered the room. Staff C walked down the hall at 12:54am and returned at 12:55am with Staff B before donning gloves and entering Resident #1's room together at 12:56am. *Staff C on rounds in the hallway at 5:36am on *Staff A looked into Resident #1's room at 8:13am on *On [redacted] Resident #1 being taken out by stretcher with Emergency Medical Services at 9:58am. A record review of hospital records conducted on [redacted] revealed that Resident #1 was assessed at Hospital #1 on [redacted] and a Computed [redacted] (CT) scan of his was completed. The CT revealed a [redacted] hematoma. Subsequently, Resident #1 was transferred to Hospital #2 and had an emergency surgery on [redacted] at approximately 1:40pm. in the afternoon. A [redacted] was performed to evacuate [redacted] hematoma. A record review conducted on [redacted] for Resident #1 revealed that Resident #1 was admitted to the facility on [redacted]. Resident #1's health assessment dated [redacted] stated that Resident #1 had a diagnosis of but not limited to [redacted], and [redacted]	A 025		

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A 025	Continued From page 4 . . . . . Resident #1 had physical limitations as abnormal gait. Resident #1 was independent for ambulation and not considered a risk. Record review also revealed physician ordered , ... , on . . . . . for a diagnosis of , , and . There were no progress notes in Resident #1's record which indicated that Staff C reported Resident #1's on . . . . . to management, on-coming staff, or primary care physician. A record review conducted on of the facility's undated policy and procedure titled "Residents prevention procedure" revealed staff on duty are to report . . to family and fill out an incident report. An interview with the Administrator conducted on . . . . . at 10:15am revealed that an incident report should be completed after an incident. She stated the incident report will have cues for the staff to notify the resident's family, case manager and doctor as their general rule. She further stated that all residents in the facility are risks due to memory care. She said "It is our procedure to have , done in house unless there is visible , a . . . . , or they are saying oww. We do a ton of , here and only 1 in 20 goes direct to 911. Staff would text us if someone is found on the floor or call us and tell us a resident so in the morning we can contact the family member. I tell them to use their best judgement as it says in the policy and to check for . . . . , palpate to check for , or for visible . . but if in doubt to call 911." A review of Resident #1's Incident/Illness Report with an incident date of at 02:00am conducted on . . . . . revealed notes stating "at 2am doing rounds [Resident #1] was found in	A 025		

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A 025	Continued From page 5 the bathroom asleep laying down on the floor with pee around him. There was also pee in the toilet." The emergency treatment and first aid section of the form was blank. A review of Resident #1's Incident/Illness Report with an incident date of . . . . . at 9:45am conducted on . . revealed a type of incident listed as "discovery of possible illness" and that resident #1 was unable to get out of bed and was not "rousable." The type of injury was listed as a behavior status change, and 911 was called to transport to the Hospital #1's Emergency Room and that he was taken from Hospital #1 to Hospital #2 for emergency surgery following the incident. It said that the primary care physician was notified on . . . . . at 3:26pm by the Assistant Administrator. It says the Administrator was notified . . . . . at (is blank) time. Additionally, there is a note at the bottom of the form that the PCPA (primary care physician assistant) was notified unknown time as it was blank when Staff A called via cell. A record review conducted on . . . . . of Staff C's account of the Resident #1's incident on . . . . . at 2:00am, handwritten record stated that Staff C was doing rounds when Resident #1's roommate said "Hey, I think my roommate's laying on the floor in the bathroom." She wrote "when I opened the bathroom door, [Resident #1] was laying down on the floor in a little bit of . There was also . . in the toilet, so I said (because he is independent) "[Resident #1], whatcha doin down there?" He was a little startled and just grunted at me. I tried to get him up and he acted like he did not want me to. So I went to get [Staff B] and we both helped him up because he seemed out of it (. . . . .). I cleaned him up and we got him into the bed. He pulled the	A 025		

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A 025	Continued From page 6 covers over him and went . . . to sleep. We noticed there was no , no bump or anything that would concern us. A record review conducted on of Staff C's account of the Resident #1's incident on at 9:00am, the handwritten record stated "in the midst of morning shift it was busy and crazy, so we weren't able to get to [Resident #1's] room. Around 9:15am a woman came in for [Resident #1] and I do not remember her name. She went and checked on his . . . . , and , . She came and got me telling me he was unresponsive. When I went in the room, [Resident #1] was twittling his ⌄ like a clapping motion and wasn't really verbally responding but was moving around. I noticed he was covered in again and sweat, so I was cleaning him off and he started ⌄ on himself and the bed, so I cleaned him up and took off his sheets. The caregiver was on the phone with the wife and daughter and they both instructed us to call 911. As I was on the phone with 911, Resident #1's wife came in and tried to arouse him. He was out of it." A record review conducted on of Staff A's account of Resident #1's incident on . The handwritten record stated "Today I [Staff A] came in and was doing my normal routine, checking all rooms and saw [Resident #1] was still asleep no problem. He sleeps in towards the middle to ending of breakfast. [Staff C] told me she checked and changed him, so I didn't bother him until around 8:15am to give out medications. I went into his room trying to give him his medications. He mumbled "no" and put the blanket over his . He normally does that when he wants to be left	A 025		

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A 025	Continued From page 7 alone. Then the LPN (licensed practical nurse) came in and came to us saying he is unresponsive, so we called 911 then." A record review conducted on of an undated Staff B's account of Resident #1's incident on . The handwritten record stated "[Resident #1] was on the ground in his bathroom when we found him asleep. We woke him up, got him off the floor, checked his , arms, and . No obvious . No , not even a scrape. When asked if he was in any , he responded with a no. Got him changed and into bed. Resident was as to why they were on the ground in the first place." A record review conducted on of an undated Assistant Administrator's handwritten account titled "[Assistant Administrator's} reporting process" revealed: * at 10:14am she received a call from Resident #1's private caregiver/companion regarding the 9:45am incident with Resident #1. * at 12:40pm She received a text for the first time from the Administrator asking if she was aware of Resident #1 having any . * at 12:57pm After interviewing high functioning residents she put a text out to all her staff asking if they saw Resident #1 . The ones that responded said "no." *On at 12:57pm she reached out to Resident #1's wife to check on his status. *On at 3:26pm I let his Primary Care Physician (PCP) know via text that Resident #1 was in surgery and asked if this could have caused his new symptoms. *On at 3:29pm the PCP called her and spoke with her and the Administrator about the morning incident and surgery.	A 025		

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A 025	Continued From page 8 *On . . . . . at 11:13pm She was told by Staff B that Resident #1 had a the night before at 2:00am where he was asked to assist. He asked her if the other person made a report for her. *On . . . . . at 11:14pm She tried to call the Administrator to report on the above but there was no answer. *On at 11:15pm She made the Administrator aware of the for Resident #1 that she had just found out about. *On . . . . . at 8:00am She made the PCP aware that Resident #1 did have a and she was made aware late. *On at 11:30am Staff C reached out to her about not coming in for her shift. *On at 1:30pm she texted Staff C to make sure she filled out an incident report but got no response. An interview with Resident #1's private caregiver conducted on . . . . . at 1:32pm revealed that her visit on was third visit and it was like night and day difference. She stated that on in the morning Resident #1 was walking, talking and active. Private caregiver stated that upon her arrival Resident #1 was not responding verbally or opening his . . She called Resident #1's wife to notify of change and facility staff called . . In a record review conducted on . . . . . of the facility training document dated . . entitled "[The Facility's Name] Procedures/Training Review with Facilitators listed as the Administrator and Assistant Administrator a protocol is listed that includes "Sometimes you will have to call 911 immediately. We ask that our staff use their best judgement as to the urgency of the situation."	A 025		

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A 025	Continued From page 9 In an interview with the Assistant Administrator conducted on [redacted] at 2:05pm, she confirmed that she was not aware of Resident #1's [redacted] until 11:12pm the night of [redacted] when Staff B came in for the night shift. She said that the Administrator had notified the PCP of the incident, but she was not sure when. She agreed Staff C "dropped the ball" and her policy is to complete an incident report immediately after the incident. She said she agreed with the Administrator that all staff needed retraining as the staff knew to notify her of the incident and did not. She said Staff C admitted she did not report the incident to her and said that it "was crazy the next morning and she forgot about it due to the craziness." Additionally, she said she did not agree with resident checks every two hours after an incident and that Resident #1 had been [redacted] and unusually calm when he was usually very attention seeking and in need of affirmation, from around [redacted] leading up to the incident and to her that was a significant change for him, and she had spoken with Resident #1's wife about it three or four times. She further stated "I tell the staff if it is just a little [redacted] on their [redacted] to send them out but if they on their arm and can move it then we don't send them out. I just wish someone had reported it and called me. Staff A did not know he [redacted] either. Staff C did not tell her. In her defense she is such a blonde and has the worst luck." In an interview with the Administrator conducted on [redacted] at 3:00pm She said that after an incident they text the doctor and sometimes they order something for the resident, and they text the case manager and document it. She said Resident #1 did not know why he was on the floor and staff did not see any [redacted] and he was not	A 025		

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A 025	Continued From page 10	A 025		

complaining of , , so they put him to bed. She said if the staff thought he had an injury they would have called 911 but they saw no marks. Additionally, she said "it was a coincidence that a private duty caregiver was scheduled to come in at 9:00am after the staff checked on him at 6:00am and 8:15am and he is known to sleep in." She said the policy is to check residents every 2 hours regardless of or potential injuries. She said Resident #1 was on camera walking with the daughter the night before and there was nothing unusual about it and that the PCP saw him on and ordered a because of that was unusual for him. Furthermore, she said "we found out the aide did correct, and we did everything we could have done, and we do not know if he hit his that night. We would not change every two-hour resident check. Some residents have hired bedside caregivers."

In an interview with Staff B conducted on at 10:35am he said that he always checks the residents who have to see if there are any obvious signs of . He said he gave Resident #1 "a quick look over and saw no , broken bones, etc." so he helped Staff C get him up off the floor and left Staff C to get him cleaned up.

In an interview with Staff F conducted on at 11:00pm, she said management preferred they call them when residents have an incident but sometimes, they do not have to. She said they would fill out an incident report and notify the next shift if a resident was sent out. She agreed that it is up to the caregivers to determine what to do if a resident has an incident.

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A 025	Continued From page 11 In an interview with Staff C conducted on [redacted] at 11:30pm she said, "if we find the resident on the floor our procedure is to check them for [redacted], bumps, scrapes or [redacted] and if nothing we put them [redacted] to bed." She stated she was busy, and the incident report slipped her mind, and she did not notify anyone of the incident on [redacted] but should have. She said Resident #1 was moving his [redacted] but was nonverbal and [redacted] that morning of the incident when the caregiver came to get her. She said that it is up to the caregivers to determine what to do if a resident has an incident. Photographic Evidence Obtained Class I	A 025		