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
	AL11910541	A. BUILDING: _____ B. WING _____	06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMER'S LANDING	615 FLORIDA AVENUE LYNN HAVEN, FL 32444

(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
CZ841 SS=D	408.823( ) FS In-person Visitation (1) This section applies to , centers as defined in s. 393.063, hospitals licensed under chapter 395, nursing home facilities licensed under part II of chapter 400, hospice facilities licensed under part of chapter 400, intermediate care facilities for the , , licensed and certified under part VIII of chapter 400, and assisted living facilities licensed under part I of chapter 429. (2)(a) No later than 30 days after the effective date of this act, each provider shall establish visitation policies and procedures. The policies and procedures must, at a minimum, include control and education policies for visitors; screening, personal protective equipment, and other control protocols for visitors; permissible length of visits and numbers of visitors, which must meet or exceed the standards in ss. 400.022(1)(b) and 429.28(1)(d), as applicable; and designation of a person responsible for ensuring that staff adhere to the policies and procedures. Safety-related policies and procedures may not be more stringent than those established for the provider's staff and may not require visitors to submit proof of any or immunization. The policies and procedures must allow consensual physical contact between a resident, client, or patient and the visitor. (b) A resident, client, or patient may designate a visitor who is a family member, friend, guardian, or other individual as an essential caregiver. The provider must allow in-person visitation by the essential caregiver for at least 2 hours daily in addition to any other visitation authorized by the provider. This section does not require an essential caregiver to provide necessary care to a resident, client, or patient of a provider, and	CZ841		

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CZ841	Continued From page 1 providers may not require an essential caregiver to provide such care. (c) The visitation policies and procedures required by this section must allow in-person visitation in all of the following circumstances, unless the resident, client, or patient objects: 1. End-of-life situations. 2. A resident, client, or patient who was living with family before being admitted to the provider ' s care is struggling with the change in environment and lack of in-person family support. 3. The resident, client, or patient is making one or more major medical decisions. 4. A resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently . 5. A resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver. 6. A resident, client, or patient who used to talk and interact with others is seldom speaking. 7. For hospitals, childbirth, including labor and delivery. 8. . . . . patients. (d) The policies and procedures may require a visitor to agree in writing to follow the provider's policies and procedures. A provider may suspend in-person visitation of a specific visitor if the visitor violates the provider's policies and procedures. (e) The providers shall provide their visitation policies and procedures to the agency when applying for initial licensure, licensure renewal, or change of ownership. The provider must make the visitation policies and procedures available to the agency for review at any time, upon request. (f) Within 24 hours after establishing the policies and procedures required under this section,	CZ841		

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CZ841	Continued From page 2 providers must make such policies and procedures easily accessible from the homepage of their websites. This Statute or Rule is not met as evidenced by: Based on electronic record review and staff interview the facility failed to publish their visitation policy on the facility website within 24 hours after establishing the policy and failed to include screening requirements for visitors within the policy and designation of the person responsible for ensuring the staff adhere to the visitation policies. The findings include: The facility website located at https://www.summerslandingalf.com was accessed in the presence of the Administrator on . . . . . at 8:55 AM. The facility visitation policy was not included on the website. The Administrator confirmed the policy was not accessible on the website and stated she received an email regarding the requirement on and she missed it. She stated the policy was last updated by the facility on . . . . . Review of the undated Re-opening Visitation policy in the presence of the Administrator revealed the policy did not contain information regarding the screening of visitors or designation of the person responsible for ensuring the staff adhere to the visitation policies. The Administrator confirmed the items were not included in the policy. Class III	CZ841		
A 000	Initial Comments	A 000		

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A 000	Continued From page 3 An unannounced complaint survey (complaint number 2022007371) and generator assessment was conducted at Summer's Landing on . . . . Deficient practice was identified at the time of the survey.	A 000		
A 025 SS=G	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		

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A 025	Continued From page 4 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 record review and staff interviews the facility failed to promptly notify the health care provider of a significant change in behavior for 1 of 1 residents reviewed who attempted self-harm and required emergent care. (resident #1) The findings include: Review of an incident involving resident #1 revealed the resident attempted to harm herself on [redacted] and was sent to the emergency room for treatment. The documentation indicated employee B, medication technician, walked into the room to assist with medications and the	A 025		

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A 025	Continued From page 5 resident stated there was . . . . all over the floor as well as the bed. She approached the resident to see where the . . . . . was coming from. There were to the top of her . . . . . , . When employee B asked the resident what happened she stated she tried to kill herself because people were after her. The resident was transferred to the hospital for evaluation. Review of the facility daily notes from . . . . through revealed no abnormal behaviors or findings. There were no daily notes for . . . . . or found in the record. An interview was conducted with employee A, medication technician, on . . . . . at 10:11 AM. Employee A stated prior to the incident on the resident had made statements about wanting to die. She talked with the resident and encouraged her to voice her feelings. She thought she reported it to employee B, another medication technician. She did not report the resident's statements to the Administrator or the health care provider. A telephone interview was conducted with employee B, medication technician on at 10:40 AM. Employee B stated it was reported that resident #1 had been up most of the night on . . . . . She stated prior to the incident the resident was out walking around in the dining room and stated she was looking for "them". She was not responding coherently and was not demonstrating normal behavior for the resident. The resident had seemed more agitated in the last few days before the incident on . . . . . Further telephone interview was conducted with employee B on . . . . . at 12:41 PM. She stated she did not report the resident's behavior to anyone prior to the incident on	A 025		

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A 025	Continued From page 6 An interview was conducted with the Administrator on at 10:35 AM. She stated she was not aware of resident #1 making any statements regarding self-harm prior to the incident on . If she would have been notified, she would have done something. A telephone interview was conducted with resident #1's health care provider on at 12:31 PM. She stated she does not recall the facility staff notifying her on any change in behaviors or threats of harm prior to the incident on . Class II	A 025		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (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. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage;	A 165		

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A 165	Continued From page 7 3. Permanent [illegible]; 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 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 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (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 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) [illegible], neglect, or [illegible] 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	A 165		

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A 165	Continued From page 8 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 this fact to such regulatory board. (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. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and staff interviews the facility failed to complete and document a thorough investigation of an incident involving a resident attempting self-harm to identify possible factors leading to the incident and develop actions plans to reduce the likelihood of reoccurrence. (resident #1) The findings include:	A 165		

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A 165	Continued From page 9 Review of an incident involving resident #1 revealed the resident attempted to harm herself on and was sent to the emergency room for treatment. The documentation indicated employee B, medication technician, walked into the room to assist with medications and the resident stated there was all over the floor as well as the bed. She approached the resident to see where the was coming from. There were to the top of her . When employee B asked the resident what happened she stated she tried to kill herself because people were after her. The resident was transferred to the hospital for evaluation. Review of the facility daily notes from through revealed no abnormal behaviors or findings. There were no daily notes for or found in the record. An interview was conducted with employee A, medication technician, on at 10:11 AM. Employee A stated prior to the incident on the resident had made statements about wanting to die. She talked with the resident and encouraged her to voice her feelings. She thought she reported it to employee B, another medication technician. She did not report the resident's statements to the Administrator or the health care provider. A telephone interview was conducted with employee B, medication technician, on at 10:40 AM. Employee B stated it was reported resident #1 had been up most of the night on . She stated prior to the incident the resident was out walking around in the dining room and stated she was looking for "them". She was not responding coherently and was not demonstrating normal behavior for the resident.	A 165		

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A 165	Continued From page 10 The resident had seemed more agitated in the last few days before the incident on . Further telephone interview was conducted with employee B on at 12:41 PM. She stated she did not report the resident's behavior to anyone prior to the incident on . A telephone interview was conducted with resident #1's health care provider on at 12:31 PM. She stated she does not recall the facility staff notifying her on any change in behaviors or threats of harm prior to the incident on . An interview was conducted with the Administrator on at 10:35 AM. She stated she was not aware of resident #1 making any statements regarding self-harm prior to the incident on . If she would have been notified, she would have done something. She stated she had no other investigation documentation other than what was provided. A follow up interview was conducted with the Administrator on at 11:42 AM. She stated the facility has a risk management and quality assurance program. She completes investigations. She did not interview the staff regarding the resident's behaviors after the incident because she already knew about the behaviors and the nurse practitioner was going to order a , and start her on . The Administrator was unable to provide any staff education completed after the incident to address the failure to report a change in behaviors to the health care provider or Administration. Class III	A 165		