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
	AL11969126	A. BUILDING: _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAPESTRY SENIOR LIVING OF TALLAHASSEE	2516 W LAKESHORE DR TALLAHASSEE, FL 32303

(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 investigation (complaint number 2022003901) and generator monitoring visit was conducted on at Tapestry Senior Living of Tallahassee. Deficiencies were identified at the time of the survey.	A 000		
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; 3. Permanent ; 4. or 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	A 165		

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A 165	Continued From page 1 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 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	A 165		

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A 165	Continued From page 2 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 interview, the facility failed to submit a preliminary and full 15-day adverse incident report for [redacted] by facility staff verified by video and audio recording for 1 of 9 sampled residents. (Resident #1) The findings include: Record review of a facility investigation report involving Resident #1 revealed that Resident #1 is [redacted], has a diagnosis of [redacted]'s [redacted], and resides on the memory care unit. Further review revealed that on [redacted] at approximately 12:55 AM, Resident #1 was escorted to her room by Staff A and Staff B, both resident assistants (RAs). Once in the room, both RAs were present while directing Resident #1 to the restroom. While standing between the	A 165		

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A 165	Continued From page 3 two RAs, Resident #1 to the floor. Staff A yelled to Resident #1 to get off the floor then walked away from Resident #1 and proceeded to adjust the air conditioner across the room. During Staff A's walk to the air conditioner, Staff A stated, "they can't blame that on you". Staff B also walked away from Resident #1 leaving her unattended on the floor. The investigation report indicated that video tape conclusively showed that Resident #1 in the room with the two RAs. Audio recording captured on the video confirms by the RAs. Video evidence also confirms neglect as evidenced by the two resident RAs walking away without assisting Resident #1 who remained on the floor. Once facility was made aware of this incident on at 2:42 PM, Staff A and Staff B were interviewed. Both staff stated they did not report this incident to the nurse. Also after facility was made aware of the incident, a nurse assessment of the resident was performed which revealed new on the area between the thumb and of the right . Record review of the facility's Prevention and Response policy and procedure revised revealed under section . Response to : Upon finding a resident on the floor from a the nurse is called to assess the situation to determine if emergency services are needed. Meanwhile, the staff member who found the resident should do the following: Ask the resident the following questions and observe for the symptoms listed: a. Do you have any new ? b. Ask resident to move all extremities and body parts. Ask the resident if they are able to do so without new , . c. Is there a change in the resident's behavior? Do they appear ? If the resident has , are they more than usual? d. Is there a change in the	A 165		

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A 165	Continued From page 4 color of the resident's skin? Are they pale? Is the extremity or ? Is there a lump, bump, or on the resident's ? e. Is there an obvious injury? Is there , seen? Is there , seen? Is a malpositioned? f. Did the resident hit their or do you suspect the resident hit their when falling? g. Did anyone witness the ? Review of subsequent instructions revealed the following: d. Documentation/follow-up e. The Tapestry employee who witnessed the or responds to the must complete the Incident Report form. The Director of Clinical Services/RN Care Coordinator/Nurse will complete their section of the incident report form. h. Document in resident record of the and the intervention performed. The caregiver should ask the resident if they are able to get up by themselves. a. If the resident can get up by themselves, the caregiver will perform standby assist or give verbal guidance as appropriate and assist the resident to move from the floor to the bed or chair. Question the resident about , after moving from floor to bed/chair. After the resident has been assisted to a safe position, the caregiver will document the in the following: i. Communicate to oncoming shift such as "check resident during night" or directions from the on-call nurse ii. Daily assignment sheet. Document the following: Who responded to the ? Who came to help? Time spent with the resident iii. Resident's weekly service charting form . Where occurred v. How and where was the resident found? vi. Document the response to the following: Did the resident have any new , ?; Did the resident demonstrate ability to move all extremities and body parts without , or per usual?; Did the resident have difficulty breathing?; Did the resident change in the resident's baseline mental status?; Was there a change in the color of the resident's skin? Was	A 165		

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A 165	Continued From page 5 there an obvious injury vii. Document that the Nurse on duty or On-Call Nurse was notified and the directions received from the nurse. Review of the facility's reporting history within the Agency for Health Care Administration's (AHCA's) electronic adverse incident reporting system revealed no report had been filed involving Resident #1. The surveyor requested documentation that this incident had been reported to AHCA. The facility was unable to produce any documentation that the verified had been submitted electronically to the AHCA's Adverse Incident Reporting System. On at approximately 2:15 PM, a telephone interview was conducted with the Executive Director (ED) who reported that he had conducted an investigation into the allegation of and it was confirmed. The ED reported that he submitted the adverse incident electronically to AHCA. The ED was informed that review of AHCA's adverse incident reporting system revealed no such submission by the facility. Record review of the facility's Identifying and Reporting Suspected Neglect or policy and procedure revised revealed the policy is to assure the protection of resident's right to be free from mental, physical, and or neglect from anyone. Review of procedures revealed all personnel are responsible for promptly reporting any suspected resident neglect or to the appropriate supervisor. The Community will fully cooperate with appropriate authorities in the reporting and investigation of suspected neglect or	A 165		

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A 165	Continued From page 6 incidents. Class III	A 165		
CZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for	CZ830		

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CZ830	Continued From page 7 overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of	CZ830		

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CZ830	Continued From page 8 licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit its comprehensive emergency management plan (CEMP) annually to the local emergency management agency for review. The findings include: The Maintenance Director provided a copy of the facility's Comprehensive Emergency Management Plan (CEMP). Review of the CEMP revealed a letter from the local emergency management agency dated that stated the 2020 plan that had been submitted was still under review. When asked for documentation that the plan had been submitted for review within the last year, the Maintenance Director reported that the Executive Director (ED) normally oversees the updates for the CEMP and the ED was currently out-of-town. On at approximately 10:27 AM, a telephone interview was conducted with the Outreach Coordinator of the local emergency management agency who reported that the facility's last CEMP required revisions and was approved on . The Outreach Coordinator confirmed the facility had not	CZ830		

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CZ830	Continued From page 9 submitted a CEMP for review since then. On . . . . . at approximately 3:15 PM, an interview was conducted with the Resident Service Director ( ) and the Executive Director (who participated via telephone). The ED confirmed he had not submitted a CEMP since receiving the last letter dated confirming review by the local emergency management agency. Class III	CZ830		