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
	AL11968586	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF VILLAGES CROSSING	13517 NE 86TH COURT LADY LAKE, FL 32159

(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 2023011059) was conducted at Harborchase of Villages Crossing on , through . Deficiencies were identified during the survey.	A 000		
A 034 SS=J	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the safe usage of assistive devices (bed rails) for 3 of 3 residents sampled, Resident #1, Resident #2, and Resident #3. On , Resident #1 was found unresponsive on the side of his bed with his between the bed rail and mattress. Resident #1 was .	A 034		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 034	Continued From page 1 Findings include: Review of Resident #1's clinical record revealed he was admitted to the facility on . . . . . Resident #1 was receiving hospice care. The resident's Personal Service Plan, dated , reads, "Resident has hospital bed with one-sided ¼ rails to assist with repositioning and turning in bed." Resident #1's Health Assessment, AHCA (Agency for Health Care Administration) Form 1823, dated , documented the resident had a diagnosis of 's and Ankylosing , , (an inflammatory . . . . . that includes , . . and stiffness in the , . . .) The record shows a physician order dated . . . . . for ¼ length bed rails. There was no documented evidence of a consent form on file for the use of bed rails, and there was no documented evidence that the mattress and side rails were checked for appropriate sizing per facility policy. Review of the hospice Nursing Assessment Note dated . . . . . reads, in part, "On call visit to ALF [Assisted Living Facility] reported , [Patient] was found . . . . . on rounds. Upon arrival to ALF met with staff [Staff B's name] and [Staff A's name], patient found on floor next to bed. Staff reported patient was found kneeling toward bed with . . . wedge between side rail and mattress, side rail pressing on left area, not breathing. Staff assisted , onto floor and called CSH [Hospice Company's Name]. Request for visit received at 02:40 AM. SN [Skilled Nurse] arrived at 02:55 AM. No , . . . no Resp [,] found, SN [Skilled Nurse] did not move body no markings on noted. pronounced at 03:00 AM. T/C [Telephone Call] to [physician's name] order received to call ME [Medical Examiner]	A 034		

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A 034	Continued From page 2 office before FH [Funeral Home]." During a telephone interview on [redacted] at 11:03 AM, Staff C, Caregiver stated she worked the night of [redacted]. Staff C stated she was doing rounds exactly at 10:00 PM, and she last saw Resident #1 around that time. During a telephone interview on [redacted] at 11:55 AM, Staff B, Medication Assistant, stated, "I arrived at the facility around 11:10 PM on [redacted] for work. I first saw [Resident #1's name] at 2:00 AM [on [redacted]] when I did my rounds. I entered the room by myself, and I saw his [redacted] on the floor. His lower part of the body was on the floor and his [redacted] was in between the rail and the mattress. I called the other staff who was halfway down the hallway. [Staff A's name] and I looked at him and he wasn't moving. I didn't check his [redacted]. [Staff A's name] and I just lowered him to the ground and put a pillow underneath his [redacted] and covered him up with a sheet that was on his bed. [Staff A's name] called hospice, and we tried to call our ED [Executive Director], but she never answered the phone. [Staff A's name] also called the previous shift who had left, and they said they had placed him in the bed at 10:00 PM. I never spoke with any supervisor at the facility that night. We did an incident report and left it in the ED's box and when she came in the next morning, she got it and texted me to call her." During an interview on [redacted] at 1:20 PM, the Administrator stated she did not have a consent form to use bed rails for Resident #1. The Administrator stated she was not aware of any documentation that Resident #1's mattress and side rail were checked for safety prior to being put in use.	A 034		

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A 034	Continued From page 3 A review of the facility monthly bed rail audit completed on . . . . . showed no documented evidence of Resident #1's mattress or side rails were checked for appropriate sizing or evidence that Resident #1 was checked periodically for safety relative to side rail use. During an interview on . . . . . at 1:30 PM, the Maintenance Director stated when Resident #1's bed and bed rail was delivered, he examined the bed and observed there was a space between the mattress and the bed rail. The Maintenance Director stated that neither he nor the delivery person placed anything between the mattress and the bed rail before the bed was used by Resident #1. During a follow up interview on at 4:20 PM, the Maintenance Director stated he did not call hospice to inform them of the space between the bed rail and mattress on Resident #1's bed. During a telephone interview on . . . . . at 8:05 PM, Staff D, Registered Nurse, an employee of [[Hospice Company's Name], stated once she opened the door to Resident #1's room, she observed Resident #1 lying . . . down on the floor covered with a blue sheet. She stated she asked Staff A and Staff B what happened, and they stated to her they found Resident #1 kneeling over the bed with his . . . . wedged between the side rail and his mattress. Staff D stated she is not a medical examiner, so she cannot say that the resident being wedged between the bed and rail caused his . . . . . Staff D stated there was a large . . . . . on the left side of Resident #1's . . . . , and it appeared that he had been wedged between the mattress and the bed rail.	A 034		

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A 034	Continued From page 4 During a telephone interview on [redacted] at 12:09 PM, Staff E, Registered Nurse, a Team Leader with [Hospice Company's Name] stated, "No, the facility did not mention anything to me about the spacing of the rails and mattress." During a telephone interview on [redacted] at 12:17 PM, Staff F, Registered Nurse, a [Hospice Company's Name] employee stated, "I visited him [Resident #1] on , , , and [redacted] and during those times no one at the facility spoke with me about the bed rails and mattress spacing being a concern." Review of Resident #2's clinical record documented the resident was admitted to the facility on [redacted]. The resident's AHCA Form 1823, dated , reads the resident has a diagnosis of Hematuria, and [redacted]. The resident requires assistance with ambulation, bathing, [redacted], grooming, and toileting. The resident requires supervision in grooming and transferring. The resident had a physician order dated for ¼ side rails to enable bed mobility with turning and repositioning and transfers with use of hospital bed. Resident #2's record also revealed an Informed Consent for the use of bedrails/siderails that was not signed by a physician. Resident #2's record had no documentation evidence that the mattress and side rails were checked for appropriate sizing per facility policy. On at 11:22 AM, an observation was made with the Administrator of the bed in Resident #2's room. The bed was equipped with ¼ bed rails attached to both sides. The bed was pushed against the wall. A review of the facility monthly bed rail audit	A 034		

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A 034	Continued From page 5 completed on . . . . . showed no documented evidence of Resident #2's mattress or side rails were checked for appropriate sizing or evidence that Resident #2 was checked periodically for safety relative to side rail use. Resident #3's record revealed the resident was admitted to the facility on . The resident's AHCA Form 1823 dated . . . . . documented the resident has a diagnosis of . . . (. . . . .), ... , and . The resident is on . precautions and requires assistance with ambulation, bathing, , grooming, toileting, and transferring. The resident requires supervision when eating. The resident had a physician order dated . . . . . for a hospital bed with a ¼ rail on one side to enable bed mobility. Resident #3's record also documented an Informed Consent for the use of bedrails/siderails, dated . . . . . , that was not signed by a physician. Resident #3's record had no documented evidence that the mattress and side rails were checked for appropriate sizing per facility policy. On . . . . . at 9:40 AM, an observation was made of the bed in Resident #3's room. The bed was equipped with a ¼ bed rail on the left side of the bed. A review of the facility monthly bed rail audit completed on . . . . . showed no documented evidence of Resident #3's mattress or side rails were checked for appropriate sizing or evidence that Resident #3 was checked periodically for safety relative to side rail use. Review of the facility policy titled, "Assistive Bed Device, Standard" revised ,	A 034		

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A 034	Continued From page 6 reads, "Procedure: 3. The use of side rails as an assistive device will be addressed in the resident's service plan/progress note to include how they assist with bed mobility, ability to change positions and/or transfer to and from bed or chair. 9. A physician order will be obtained for the use of the side rail. The physician will also need to sign the consent form. 10. When side rail usage is appropriate, the community will examine the space between the mattress and side rails (to reduce the risk for entrapment as the amount of safe space may vary, depending on the type of bed and mattress being used), prior to the resident using the device. 11. The staff will document that the mattress and side rails were checked for appropriate sizing at the time the side rails were placed. The resident will be checked periodically for safety relative to side rail use, and/or State specific guidelines." During an interview on [redacted] at 10:55 AM, the Administrator stated the policy (for assistive bed devices) was revised in 2017 and was not being followed. The Administrator stated that no one was examining or checking the beds for residents who used bed rails. She stated she did not have documentation for any residents that use ¼ bed rails that their mattresses and side rails were checked for appropriate sizing at the time the side rails were installed. Class I	A 034		