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
	AL11963839	A. BUILDING: _____ B. WING _____	09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESERVE AT CITRUS	2341 W. NORVELL BRYANT HIGHWAY LECANTO, FL 34461

(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 numbers 2023013363 and 2023013366) was conducted at The Reserve At Citrus on , , through , , and , . Deficiencies were identified at the time of the survey.	A 000		
A 025	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 025		

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A 025	Continued From page 1 (a) Monitoring of the quantity and quality of 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 interview and record review, the facility failed to notify a resident's health care provider after a resident exhibited a significant change in condition for 1 of 3 residents sampled, Resident #2. Findings include: Review of Resident #2's Resident Health Assessment documented the resident was admitted to the facility on . Resident #2's relevant diagnoses included communication	A 025		

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A 025	Continued From page 2 , and right branch (a problem with the 's ability to conduct electrical signals.) The resident was noted to have a lack of coordination and needed a walker and wheelchair for mobility assistance. It was also documented that the resident was alert to self, , and forgetful. Review of the progress note written by Staff H, Medical Assistant (MA) on at 4:08 PM read, "Resident [#2] complained of , all over tiredness all day, he is sleeping a lot and seems a little . He could not specify what was wrong so I text {sic} [Advanced Practice Registered Nurse's (APRN) name] for a UA [ ] order. His vitals were T [temperature] 97.5, HR [rate] 102, [ ] 100%." Review of facility records documented a faxed order received from the APRN on (no time noted) for a for Resident #2. There was no documentation found in the resident's record that a was completed. Review of the progress note written by Staff H, Medical Assistant (MA) on at 7:49 PM read, "Resident [#2] had an unwitnessed at approximately 5:25 PM. He stated that he went a bit before slipping off his bed. He was found by 2 aides. I attended and saw the resident on the floor next to his bed with his propped up against his nightstand. Resident stated he knocked his but it did not cause him any . I looked for injuries to the of his and none were apparent. I asked if he was in any and he said no his vital signs (VS) were %..." Review of the progress note written by Staff B,	A 025		

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A 025	Continued From page 3 Licensed Practical Nurse (LPN) on at 4:00 PM read, " ... complaint of stuffiness left ..." Review of the progress note written by Staff B, LPN on at 3:07 PM, "... Resting in bed most of the day. No specific complaints voiced. VS [ ], P [,] 84, R [,] 20, T 97.2 ..." Review of the progress note written by Staff B, LPN on at 9:12 PM, " ...VS 97.9 [T], , unable to be obtained ..." There was no documentation that Resident #2's physician was notified on following the resident's low , readings. Review of the progress note written by an unknown staff member with an unidentifiable signature on at 12:45 PM read, " ...resident [#2] did not touch his soup and encouraged resident to eat ..." Review of the progress note written by the Resident Care Director (RCD) on at 3:36 PM read, " ...At approximately 1:25 PM the dietary aide [dietary aide's name] was cleaning up plates in the dining room she heard resident make a {sic} odd noise, she turned around and saw resident had his tilted and was breathing in and out deeply through his , breaths sounded rattly ...called name twice and no response, saw his body weaken and his color shift ... 911 called told the dispatcher that the resident was a . The dispatcher told us to do (, ,). Resident moved to room." Review of the Citrus County Sheriff's Office Calls	A 025		

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A 025	Continued From page 4 for Service log revealed Emergency Medical Services personnel responded to the facility on [redacted] and declared the resident [redacted] at 1:39 PM. During an interview on [redacted] at 2:40 PM, the Director of Nursing (DON) stated that [Resident #2's name] was able to urinate. She stated there was never a requisition placed for the [redacted], and no [redacted] ever obtained from Resident #2 that she could locate. The Director of Nursing confirmed the order was written on [redacted] and the resident [redacted]. During an interview on [redacted] at 4:20 PM, the DON stated that when the residents [redacted], their normal protocol is to call the doctor and family, and if the resident is injured, the send the resident to the emergency room. [Resident #2's name] should have been sent to the emergency room after the [redacted] because he hit his [redacted]. She stated, "[Staff H's name] the Medical Assistant did not follow our process and did not call the doctor. I did talk to [Staff B's name] about not calling the doctor when [Resident #2's name] had a drop in his [redacted]. When patients have a change in status the physician and family are to be informed and patients are sent to the emergency department." During an interview on [redacted] at 9:36 AM, Resident #2's APRN stated that she had received a text on [redacted] at 3:39 AM from the MT [Staff H] informing her that [Resident #2's name] was [redacted] and requested a [redacted]. The APRN stated, "I faxed over the order. [Resident #2's name] was [redacted] and alert and he would be able to provide [redacted], so I would expect the [redacted] to be completed by [redacted] the 12th." She stated that she did not receive a call when	A 025		

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A 025	Continued From page 5 Resident #2 and hit his , and he should have been sent to the hospital per protocol. She did not receive a call when his , dropped. The APRN considered the , of and to be too low and stated, "This is definitely a change in condition because he already had . I would have told them to send him to the emergency department if I had received a call." During an interview on at 3:15 PM, the DON stated she did not receive a call related to [Resident #2's name] or drop in , . During an interview on at 10:37 AM, the RCD stated, "I don't know why the doctor was not called when [Resident #2's name] or why he [physician] was not notified when his , dropped." During a telephone interview on at 10:56 AM, Staff B, LPN stated she did not remember writing out a requisition for a , for [Resident #2's name]. Staff B stated, "When I seen {sic} his , was so low, I thought he was , so I started encouraging and pushing fluids. The family was here, and I discussed with the family that he may be , so I want to encourage him to drink. I did not call the doctor or the Administrator. Normally I would call [DON's name] the DON but I did not see the need. I know I should have called the doctor and reported the low , now." Review of facility policy titled, "Resident Emergency- and Injuries," dated 2018, stated in part, "Treatment of Injuries, 1. General Injury - A bump or a while	A 025		

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A 025	Continued From page 6 the . . . was injured: a. Call 911; the resident should see a trained medical person." Review of facility policy titled, "Recognizing a Resident Emergency," dated 2018, stated in part, "3. Signs that could indicate a medical emergency include but are not limited to: b. . . . , ... increase or decrease of 20 mm Hg [millimeters of mercury.] 4. When an emergency occurs, any staff member may assess the situation and call 911. 911 should be called when it is thought that 911 services would help the situation, even if there is doubt as to whether or not the situation is an actual emergency. 7. It is the supervisor's responsibility to report and coordinate the management of changing medical conditions with the resident's primary healthcare provider, the resident and/or resident's family or representative, and staff." Class I	A 025		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow	A 030		

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A 030	Continued From page 7 residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation.	A 030		

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A 030	Continued From page 8 Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from _____ and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened	A 030		

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A 030	Continued From page 9 correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , , , , , , , , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.	A 030		

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A 030	Continued From page 10 (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally [illegible], the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without [illegible], interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, [illegible], and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free	A 030		

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A 030	Continued From page 11 telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that	A 030		

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A 030	Continued From page 12 which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to act in accordance with a resident's advance directives and to honor the resident's wishes of ( ) when found unresponsive and absent of vital signs for 1 of 3 residents sampled, Resident #2, which did not allow the resident to experience a natural . Findings include: Review of Resident #2's Resident Health Assessment documented that the resident was admitted to the facility on . Resident #2's relevant diagnoses included communication , , , , , , and right branch (a problem with the 's ability to conduct electrical signals.) The resident was noted to have a lack of coordination and needed a walker and wheelchair for mobility assistance. It was also documented that the resident was alert to self, , and forgetful. Resident #2 had a State of Florida signed on by the resident's APRN (Advanced Practice Registered Nurse). Resident #2's resident record sheet included a section titled, "CODE STATUS / ADVANCE DIRECTIVES." The Code Status was listed as " ." A progress note written by the Resident Care Director (RCD) on at 3:36 PM read, "At	A 030		

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A 030	Continued From page 13 approximately 12:45 PM Med Tech [Staff G's Name] asked resident what he wanted for lunch, resident stated that he wanted fish and soup. Resident put the crackers in his soup and then [Staff G's Name] brought resident his fish, [Staff G's name] notice that resident did not touch his soup and encourage {sic}resident to eat. At approximately 1:25 PM the dietary aide [dietary aide's name] was cleaning up plates in the dining room she heard resident make a {sic} odd noise she turned around and saw resident had his ... tilted and was breathing in and out deeply through his ..., breath sounded rattly. She stated she called his name twice and no response, saw his body weaken and his color shift so she went and grabbed Med Tech [Staff G's name.] Med Tech [Staff G's name] came and grabbed this writer. We observed [Resident #2's name] slumped over in his wheelchair. This writer ran to call 911 and [Staff G's Name] grabbed another aid [Staff F's Name] to help her with resident to take him to his room. I called 911 told the dispatcher what was going on and told the dispatcher that resident had a . The dispatcher told us to do [... ... ...] I kept telling the dispatcher that resident had a . The dispatcher stated he could not see the , so we had to do ... ... I told [Staff G's Name] that we needed to start , {sic}. The dispatcher wanted me to put the phone on speaker and go to residents' room, I had to give them my cell phone number. The dispatcher called me at 1:32 PM, I was in the room, and they were doing ... ... on the resident, I kept saying to the dispatcher that he has a ..., the dispatcher was counting with [Staff G's Name]. Then [Staff A's name] Med Tech was in the room and switched ... with [Staff G's Name]. At approximately 1:35 PM the	A 030		

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	AL11963839	A. BUILDING: _____ B. WING _____	09/11/2023

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A 030	Continued From page 14 paramedics came into residents {sic} room, as soon as the paramedics walked in they saw the in my and said to stop doing , {sic}. [Staff G's Name] stopped doing , {sic}. I notified the son and the ARNP {APRN}." Review of the Citrus County Sheriff's Office Calls for Service log revealed Emergency Medical Services personnel responded to the facility on and declared the resident at 1:39 PM. During an interview on at 10:26 AM, the RCD stated that when Resident #2 coded, she was on the phone with 911. The Resident Care Director said she told the dispatcher that [Resident #2's name] had a , but she was told that they had to perform . The RCD stated, "I kept telling him over and over that he was a . I didn't know what to do because they directed us to do , so I did." During an interview on at 3:50 PM, Staff G, Med Tech stated that 911 is called for any code, even because the is an untimely . Staff G stated, "I did not initially start because he was a , but when 911 told us that we had to do I was and did not know what to do. I started because I didn't have a choice." During an interview on at 9:36 AM, Resident #2's APRN stated he had a and should never have been started. The APRN stated that can cause broken , if responsiveness occurs, , and return of spontaneous circulation which may prolong life.	A 030		

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A 030	Continued From page 15 During an interview on . . . . . at 3:15 PM, The Director of Nursing stated, "I told [Resident Care Director's name] when she told me about [Resident #2's name] dying and the staff giving . . . they should have not done that. No education was given related to . . . 's because this has never happened before, and they were directed by . . . (Emergency Medical Services) to do it. All the staff felt that they had to follow . . . 's directive." During a telephone interview on . . . . . at 11:31 AM, Staff A, Med Tech stated, "I did assist with . . . for [Resident #2's name.] I know if they have a . . . we are not supposed to . . . . . , but we were all . . . because . . . was telling us that we had to, so I did." Review of facility policy titled, "Protecting Resident Rights," dated 2018, stated in part, "Resident Rights, 2. The resident has a right to a quality of life that supports independent expression, choice, and decision-making, consistent with residency requirements and applicable law and regulation. 4. The resident has a right to personal freedom and dignity. 22. The resident has a right to formulate advance directives." Class I	A 030		
A 055	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both	A 055		

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A 055	Continued From page 16	A 055		

prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents.
(b) Both prescription and over-the-counter medications for residents must be centrally stored if:
1. The facility administers the medication;
2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request;
3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;
4. The resident fails to maintain the medication in a safe manner as described in this paragraph;
5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or
6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C.
(c) Centrally stored medications must be:
1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times;
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or

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A 055	Continued From page 17 by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return	A 055		

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A 055	Continued From page 18 dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to properly dispose of a former resident's medications within 30 days of being determined to have been abandoned for 1 of 3 residents reviewed, Resident #5. Findings include: During an observation on . . . . . at 2:33 PM, a secured cabinet located in the memory care unit was observed to contain abandoned medications belonging to Resident #5. Resident #5 was discharged from the facility on . . . . . . (Photographic evidence obtained.) During an interview on at 3:15 PM, the Director of Nursing stated that she should be destroying the abandoned medications that are left at the facility for greater than 30 days. She stated that she does not do this routinely and needs to do a better job. Review of facility policy and procedures #11.26 titled, "Medication Management," Revised . . . , ... read, "Outdated, damaged, and contaminated medications will be checked, identified, returned or destroyed monthly." Class III	A 055		