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 |
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| A 000 | Initial Comments<br><br>Assisted Living Facility<br><br>A complaint survey, CCR# 2012008149, was completed on [redacted].<br><br>The Grand Court of Tampa assisted living facility had a deficiency found at the time of the visit. | A 000 | | |
| A 030 | 58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures<br><br>(6) RESIDENT RIGHTS AND FACILITY PROCEDURES.<br>(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 Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C.<br>(b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for 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.<br>(c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with Disabilities, [redacted]2-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.<br>(d) The statewide toll-free telephone number of | A 030 | | |

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the Florida ..... Hotline " 1(800)9€ or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s ..... and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.
(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.
(g) The facility shall 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 shall not prohibit 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 shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.
(h) Pursuant to Section 429.41, F.S., the use of physical ..... shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the

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resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical [redacted].

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 [redacted] 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 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 achieve 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

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attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a 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) Access to adequate and appropriate health care consistent with established and recognized standards within the community.
(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 , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. 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 interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right

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| A 030 | Continued From page 4<br>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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, record review and interviews, the facility failed to honor residents rights to a safe and descent living environment by not following the illness outbreak management recommendations given by the Department of Health- which might have prevented the further spread of a virulent outbreak that affected 30 residents out of 97; a sample of 17 residents was selected including affected and unaffected assisted living and independent living residents (all live in the same community) and included 5 residents who required transport to the emergency and/or hospital admission (#6, #7, #17, #18 and #19); plus 9 care staff including direct care and food service staff, who were also affected.<br><br>Findings include:<br><br>1. Observation during the tour beginning at approximately 9:00am revealed a cautionary sign posted on the glass doors as one entered the facility indicating there were many cases of and that was spread from person to person. To the right as you entered the facility was another sign near the elevators indicating activities had been canceled and in the elevators was a sign that the dining would be closed until further notice.<br>sanitizer was observed at the front desk. The sign | A 030 | | |

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in and sign out sheet had been removed and all of this was reportedly taken over by the Concierge staff in order to prevent persons from sharing writing utensils. The main dining [illegible] blocked off with chairs going across the entryway. The tables were set and still had salt and pepper shakers on them which could be accessible to anyone if they could get into the dining [illegible].

2. Interview with Resident #2 on [illegible] at approximately 10:00am revealed she had just returned on Monday and was not alerted until Wednesday when the dining [illegible] abruptly closed.

3. Interview with Resident #3 (independent living resident) at approximately 9:20am who was sitting in the main lobby revealed she was not aware of any illness and did not know why the dining [illegible] closed.

4. Interview with Resident #4 on [illegible] at approximately 10:00am in her apartment revealed she thought she had been left a note on her door. She indicated that she had commented to a server staff member that her apron was dirty. She said the staff (who she could not identify) told her they (staff) are responsible for cleaning their uniforms (apron) and that she had not had time to clean it the prior night. The resident went on to say the food does not always have covers on them which concerns her.

5. Interview with Resident #5 on [illegible] at approximately 10:10 a.m. in the lobby revealed the night before last, I went down to the dining [illegible] they met us at the door and told us the dining [illegible] closed and they would bring us our meals. She said she had not noticed a

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different approach to the way things had been cleaned by her housekeeper and that she typically has the same housekeeper.

6. Interview with Resident #6 on at approximately 10:25 a.m. in her apartment revealed she had come down with initially in the morning hours of Monday. She remembers waking up around 8:30 a.m. with and She was assessed by nurses and sent via 911 to the hospital. She went on to say her symptoms were severe and very fast, and because of a diagnosis of it was imperative that quick action was taken. She said she returned to the facility on Wednesday She had no symptoms currently. She went on to describe the seafood/crab dinner meal she had eaten on Sunday which she thought may have been the source of her illness. She recalls a memo was sent around notifying residents that meals would be brought to them, and they were encouraged not to go downstairs.

Record review revealed Resident #6 had a health assessment dated with diagnoses including and gallstones. Her activities of daily living (ADLs) were listed as needing supervision for all except independent in eating. Nursing notes written on revealed she was was transported to the ER on due to S/S of and returning on Just before the interview began, 2 direct care givers were observed in her her with toileting. Both staff were wearing gloves but neither were wearing gowns.

7. Record review revealed Resident #7 had a health assessment dated with the following diagnoses: fib, nursing notes revealed

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it was reported to staff that the resident was weak and was . She was transferred out via 911 and remained hospitalized on the day of the survey. She had been hospitalized most recently on due to level being 6.7 and ordered to be hospitalized. It could not be determined by the surveyors if the resident's condition was exacerbated by the since loss of during would tend to deplete the level.

8. Interview with Resident #9 at approximately 11:00 a.m. on revealed she was active in the Resident Council, specifically working in the dining area. She stated the salad bar was closed before the dining . She said an info sheet was given to each resident. She said the staff were wiping down her walker with an unknown

9. A tour at 9:45 a.m. on , started on 12th floor, included interview with a visiting home health aide for Resident #12 who told the surveyor she had been made aware of an outbreak by the facility prior to coming here. She said she comes 5x week. Residents have and are

10. A 10:00 a.m. interview with resident #10 revealed she had the approximately 4 days ago and is fine now.

11. Record review revealed Resident #17 developed signs and symptoms of and on . She was sent to the ER via 911 and returned on .

12. On at 9am an interview with the acting administrator (in the administrator's

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absence) was conducted to determine what actions the facility implemented to combat the outbreak of the communicable illness. During this interview the following information was obtained:
On , the first 2 cases where residents complained of , cramping, , and , signs and symptoms (S/S) was documented.
On , there were 14 more cases of residents becoming ill reported with cramping, , and , S/S, 13 of the residents were assisted living (AL); 5 of the AL residents required transportation to local hospitals and 3 of those residents were admitted to the hospitals. Also 3 staff members reported similar S/S. Residents who had S/S of the illness were encouraged to report them to nursing staff and stay in their apartments up to 2-3 days after S/S stopped.
On the morning (time unknown) of , (Monday), the Hillsborough County Department of Health (HCDOH) was contacted by phone related to this outbreak. Preliminary recommendations included limiting Activities for residents. The facility shut down its buffet salad bar. At approximately 4:30pm, the HCDOH conducted a tour of the facility with the administrator, gave verbal recommendations -including removing salt and pepper containers from the dining , and replacing them with individual packaged salt and pepper packages, also to remove all condiments from the tables and only offer them to residents when requested. Stool sample containers, to be used identifying the cause of the outbreak, were given to the facility. Six more cases were reported with similar S/S. Four of those were AL, 1 was a staff member and 1 was independent living (IL) resident.
On , a total of 8 cases with similar S/S were reported. 4 of those were AL, 3 were staff

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and one was IL.
On , after lunch, the facility ceased serving meals in the dining and delivered all meals/beverages to residents' apartments. The facility also received the faxed written recommendations from the HCDOH which included the above mentioned verbal recommendation in regards to the dining . The HCDOH also included the following recommendation; Provide dedicated housekeeping staff with gowns, gloves and mask to care for incidents and apartments of ill residents. There were 7 new cases of the outbreak reported including 4 AL residents, 2 staff members and 1 IL resident.
On , 4 more cases were reported - 3 AL residents and 1 staff member. No new hospitalizations of residents reported Interview with the administrator via phone on at approximately 1:30 p.m. revealed no new cases on 07/2 case on Saturday and 1 case on Sunday. Additionally he said that the dining room was not available during the survey revealed she had heard the inspector from the HD say to take the salt and pepper shakers from the tables, which they did, but did not understand this to mean they couldn't clean them and put them back on the table. He said they used them again the next day (Tuesday) and (Wednesday) through lunch until the HD returned but thought they were within the guidelines as they understood them. The dining room down after lunch on Wednesday.

13. On 7/25 HCDOH revisited the facility to pick up sample containers. Upon their arrival they noticed that there were no signs posted warning residents or visitors of possible exposure of a communicable illness. They also noticed that the tables in the main dining room salt

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and pepper containers on them. On , the HCDOH confirmed the outbreak was linked to the .

14. On at approximately 11:30am, an interview with the kitchen manager was conducted. At that time he stated that the salt and pepper containers were removed from the tables on . Their contents were removed and they were washed, refilled and placed back on the table. He did state he was made aware of the HCDOH verbal recommendations about the containers on and the faxed written recommendations on .

15. On at 12pm, an interview with the assistant housekeeping supervisor. She stated that she was made aware of the outbreak on when she reported to work. She stated housekeeping staff are on duty at the facility from 7 am to 3:30pm Monday through Friday and no housekeeping staff work on the weekends. She said direct care staff or maintenance provide housekeeping duties on the weekends if needed. She confirmed she was informed of the faxed written HCDOH recommendation about providing dedicated housekeeping staff to clean apartments of residents. She said she assigned a staff member (housekeeping) Staff G to do the majority of the cleanup of residents but other housekeeping staff also had assisted with the cleanup of residents' apartments.

On at 12:10pm, an interview with housekeeping Staff G was conducted. At that time she confirmed she did the majority of housekeeping duties of residents' apartments. She stated that she was provided three disposable gowns from the director of nurses

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(DON). She was provided disposable masks and gloves. She was also provided in-service on proper hand-washing with warm water and soap, donning and removing the gowns, a cleaning solution of bleach/water mix that was exchanged every 24 hours.

On at 12:30pm, an interview was conducted with the DON. She stated she was aware of the verbal and faxed written recommendations from the HCDOH concerning dedicated housekeeper staff to cleanup residents' apartments. She stated she provided three disposable gowns to housekeeping staff. She also stated the facility had 10 personal protection equipment (PPE) kits available. She stated that direct care staff had not been issued disposable gowns to wear when assisting residents or to use when housekeeping was not available to clean up after residents.

16. On at 1:20 p.m. the administrator arrived. He stated he was at the facility on (Monday) and did get the verbal recommendations from the HCDOH regarding removing salt and pepper containers from the tables. He was also aware of the faxed written recommendations regarding dedicated housekeeping staff and having them use gown, gloves and mask when cleaning residents' apartments. He did state the salt and pepper containers were left on the table as an oversight by him and the kitchen manager and could not recall if the dining was in the the HD came out and gave the recommendations. He did not have an explanation as to why ample numbers of disposable gowns were not ordered or available before the surveyors arrived on .

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| A 030 | Continued From page 12<br><br>17. On . at approximately 3pm, a walk by was done of the main dining . All containers, napkins and silverware were removed from the tables. The signs stating dining . closed were still posted and chairs were blocking the entrance to the dining .<br><br>Class II<br><br>Widespread | A 030 | | |

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

*Better Health Care for all Floridians*

ELIZABETH DUDEK
SECRETARY

. 2012

Administrator
Grand Court Tampa
4902 Bayshore Blvd
Tampa, FL 33611

Dear Administrator:

Re: **CCR# 2012008149**

This letter reports the findings of a complaint survey that was conducted on . 2012, by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiency identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia Reid Bateman
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

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