STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969017	08/16/2018
NAME OF PROVIDER OR SUPPLIER **WATERMARK AT TRINITY (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **1960 BLUE FOX WAY** **TRINITY, FL 34655**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

Assisted Living Facility

A Complaint Survey (CCR#: 2018012334) was conducted at Watermark at Trinity Assisted Living Facility on . Watermark at Trinity Assisted Living Facility had deficient practice identified at the time of the survey.

(License#: 12868)

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, interview, and record review, the Facility failed to provide oversight necessary to protect residents from harm and the Facility failed to follow their own policies for keeping residents secure and for monitoring the whereabouts of one of one sampled residents (Resident #1). This resulted in Resident #1 exiting the Facility's outside into the for an unknown amount of time on a hot day with a high temperature of 91 degrees. Resident #1 was eventually partially and with no This lack of oversight put all twenty Residents at immediate risk of harm.

Findings Included:

Observation during a tour of the Facility's conducted on at 02:35pm, revealed that the Hall A doors leading to the outside were not alarmed and not secured. The green lights were on which indicated that the doors were left unsecured. The Hall A doors remained unsecured through 03:17pm.

Further observation during the tour of the revealed that the outside was on the side of the building and was in direct sunlight during the afternoon.

During an interview with Staff D, conducted on at 03:36pm, Staff D stated that on between 05:00pm and 05:30pm that Staff A, "called me down ASAP (as soon as possible)." Staff D entered the and saw that Resident #1 was in the , and had all over [the resident's] , which was "more har ' Staff D indicated that Resident #1 had Both the right and left of Resident #1's were and to the touch. Resident #1's ' and were on the opposite side of the pathway." Per Staff D, Staff A called the

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Assistant Director of Nursing via phone and then directed Staff D and other staff present to "get [Resident #1) cleaned up and dressed." Per Staff D, Staff A then proceeded to wash Resident #1's and "I went and got a blanket to cover (Resident #1)."

During an interview with Staff A, conducted on at 06:41pm, Staff A stated that Resident #1 was in the by Staff E. Staff A was upstairs assisting residents with medication and vital signs. Per Staff A, Staff E notified Staff A at approximately 05:06pm and Staff E stated that Resident #1 "didn't have [and] we did the best we could to put [them] for [Resident #1's] " Staff A stated that it was normal for Resident #1 to walk around outside. Staff A stated that it was normal for Resident #1 to

During an interview with Staff E, conducted on at 06:50pm, Staff E stated that on , Resident #1 was found with , or on." Staff E stated that Staff A directed staff to Resident #1. Staff E stated that the doors to the were not alarmed during the second shift on . Staff E stated that there was no a head-count of residents performed at supper on .

A review of the ( ) report from , conducted on , revealed that was to the Facility at 06:01pm and arrived on scene at 06:07pm. The report stated that Resident #1 showed signs of " and and that staff stated that they had not seen [Resident #1] for 30-40 minutes." There was no documentation in the report that Resident #1 was and had on the .

Review of a local weather report revealed the high temperature in the area on (the date of the incident) was 91 degrees.

Per www.medicinnet.com: "Those most susceptible individuals to include the elderly ((often with associated , , , or who are taking medications that make them to and .) is a form of or related an abnormally elevated with accompanying physical symptoms including changes in the function. is a true medical emergency that is often fatal if not properly and promptly treated."

A review of Resident #1's record conducted on , revealed that Resident #1 had , decline, was an risk, and a risk (See Photographic Evidence1.) Prior to the event that occurred on , Resident #1 had a documented significant decline in condition, including multiple within the previous thirty days, which warranted a Physician's order for a consult

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with on .
Further review of Resident #1's record on revealed that Resident #1 was prescribed on (Photo Evidence1 obtained).

According to Drugs.com, common side effects of include: dizziness, drowsiness, blurred vision, confusion, poor coordination, sensitivity to sun

During an interview conducted on at 03:08pm, the Director of Nursing stated that the doors "are secured and there are alarms on the doors."

During an interview with Staff G, conducted on at 03:16pm, Staff G stated that the doors "are always locked and we do 15-minute checks just in case."

During an interview with Staff C (the second shift Supervisor) conducted on at 03:17pm, Staff C acknowledged and confirmed that the doors were found not alarmed on the date of survey and had not been alarmed. When interviewed specifically about the Facility's policies for securing the Staff C stated that the Facility does not document 15-minutes checks for the residents.

During an interview conducted on at 3:30 PM with Staff B, who worked the date Resident #1 was in the , Staff B stated that the "doors to the outside patio are left unlocked all day and residents can go in and out by themselves."

During an interview with the Administrator, conducted on at 05:37pm, the Administrator said there was no Policy and Procedure for the doors and alarms. The Administrator stated that the Facility does not document alarm checks performed by staff or maintenance personnel.

During an interview with the Assistant Director of Nursing, conducted on at 06:53pm, the Assistant Director of Nursing confirmed that Resident #1 had and "."

During an interview with the Facility's Director of Nursing, conducted on at 07:12pm, the Director of Nursing stated that no written statements from Facility staff and witnesses were taken and there was not an investigation conducted post-event.

During an interview with the Administrator, conducted on at 07:30pm, the Administrator stated that the camera video from was reviewed on from the period of 10:00am until arrived on scene. The video recording was not maintained after the incident but still pictures/snapshots were taken. These pictures were reviewed by Facility Administration and, per the

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administrator, found no activity occurred in the until arrived on scene. On at 07:47pm, the Administrator denied any knowledge of Resident #1 being Agency staff tested the video camera and the video camera detected one Surveyor exiting and reentering the in the

During an interview with a Visitor at the Facility, conducted on at 08:35pm, the Visitor stated they arrived at the Facility's at approximately 04:40pm on and Resident #1 was not at the dining table. The Visitor further stated that no one went in or out of the Hall A doors while the Visitor was in the area visiting another Resident. The Visitor stated that they observed Facility staff directed by Staff A to dress Resident #1 and Facility Staff did not call 911 immediately. The Visitor stated that, "I had to stop residents from going outside; they wanted to know what was happening; and the staff isn't trained properly to handle an emergency."

A review of the Facility's Policy and Procedures for (See Photographic Evidence2), conducted on , revealed that the Facility did not follow the Policy and Procedure. Section C-2 stated that sliding door restrictors should guard against Section E stated that, "routine checks should be documented." Section F stated that, "the maintenance department should check door alarms weekly, delayed egress doors and any other systems installed to insure the safety of our RSs." Section G stated that, "Program Director, Director of Nursing or Designee should ensure that there is a process for door alarms to be checked every shift and documented." Section H stated that, "the door alarm test should be documented on the Door Alarm Log."

A review of the Facility's Policy and Procedures (See Photographic Evidence3) for finding an resident, conducted on , revealed that when staff find an resident that 911 is to be called immediately. The Policy and Procedure of the Facility's Courtyard Protocol was that "the Courtyard door will remain secured at all times."

On at 09:15pm, the Administrator stated that the Facility does not keep a log of door alarm checks. The Administrator further stated that maintenance personnel does not check the doors.

Class I

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on observation, interview, and record review, the Facility failed to submit a complete and accurate

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Adverse Incident Report for an adverse event (of Resident #1, event reported to for investigation) over which the Facility could exercise control.

Findings Included:

A review of an Adverse Incident Report (AIR) filed for the of Resident #1, conducted on , revealed that Resident #1's occurred while the resident was unattended in the It was undetermined how long that Resident #1 had been outside in the elements of a hot 91-degree day. The AIR stated that routine outdoor assurance checks were conducted and that Resident #1 was and only 15-minutes prior to being Investigation of the incident revealed that this was not accurate. The initial AIR was submitted to the Agency for Health Care Administration on at 09:08pm and the full AIR was submitted on at 03:08pm. Both AIRs were submitted by the Facility's Director of Nursing (DON).

During an interview with Staff D conducted on at 03:36pm, Staff D stated that Staff A, the Licensed Practical Nurse Supervisor "called me down ASAP (as soon as possible)." Staff D entered the and saw that Resident #1 had was partially and had on the , which was "more than Both the right and left of Resident #1's were and to the touch. Resident #1's " were on the opposite side of the pathway." Staff A called the Assistant Director of Nursing (ADON) and stated that the ADON ordered for Resident #1 to be clean and and Staff A proceeded to clean Resident #1's . When the ADON arrived, the ADON ordered the Staff to get inside the building. The DON arrived after the emergency medical support arrived and the DON took over. This information was not described in the Adverse Incident Report filed with the Agency for Health Care Administration (See Photographic Evidence5).

A review of the Emergency Medical Support report, conducted on , revealed that the to the Facility at 06:01pm, arrived on scene at 06:07pm. The report stated that Resident #1 showed signs of ' and ' and that staff stated that they had not seen [Resident #1] for 30-40 minutes." There was no documentation in the report that Resident #1 was and had on the .

During an interview with Staff A, conducted on at 06:41pm, Staff A stated that Resident #1 was in the and at 05:06pm and Resident #1 was not fully and that "we did the best we could to put [the] ."

During an interview with the ADON, on at 06:53pm, the DON stated that when I arrived (after

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Resident #1 "had all "

An interview with a Resident Family Member visiting the Facility, conducted on at 08:35pm, revealed that Resident #1 was not in the dining room for dinner at 04:40pm on . The Family Member said that Staff E observed a pile of outside in the and went to investigate shortly after 05:00pm and Resident #1 and The Family Member stated, "No one went in or out the door after 04:45pm."

During an interview with Staff E, conducted on at 06:50pm, Staff E stated that Staff A, ordered Resident #1 to be prior to calling 911 and was unsure about the timeframe. Staff E stated that the doors were not alarmed/secured on when Resident #1 went Staff E stated that "all the lights were all green that shift." Staff E stated that the head count for residents was not performed that shift and stated that, "it was really busy ...."

During an interview with the Administrator and the Director of Nursing, conducted on at 07:47pm, the Administrator indicated that the investigation of Resident #1's incident was not investigated thoroughly and that no witness statements were obtained. The Administrator stated that both the Administrator and the Director of Nursing were going away for a Cooperate Conference on Monday, . The Director of Nursing stated that questions were asked of the Staff involved but an investigation was not conducted.

The high temperature for the area on was 91 degrees.

Class III