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	AL11964377	**11/14/2018**
NAME OF PROVIDER OR SUPPLIER **SUNNY HILLS OF SEBRING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3600 COMMERCE CENTER DR** **SEBRING, FL 33870**	

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Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview, the facility failed to maintain an up-to-date Background Screening Clearinghouse (BGS) Roster for one (Staff D) who is no longer employed at the facility.

Findings Included:

A record review of the Agency for Health Care Administration Clearinghouse Facility Employee Roster on revealed Staff D listed on the roster with a hire date of and no end date.

Record review of the facility's current list of employees provided by the Director of Nursing (DON) revealed Staff D was not on the list.

During an interview with the DON conducted on at 8:40am, the DON confirmed Staff D's last day of employment was and the BGS Roster was not up-to-date.

Unclassified

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0000 - Initial Comments

Assisted Living Facility

A complaint investigation (CCR#2018016435 and CCR#2018016447) was conducted on for Sunny Hills of Sebring (License #9001) an assisted living facility in Sebring, Florida. At the time of the survey, the facility had deficient practice.

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

Based on observation, records review and interviews, the facility failed to provide personal supervision and oversight required for each resident to include awareness of general health, safety and well-being of the resident for 1 of 27 residents (Resident #1) on the facility's memory care unit. This lack of oversight and awareness led to Resident #1's hospitalization and subsequent after prolonged exposure to outside temperatures over 90 degrees Fahrenheit in the facility's memory care courtyard and placed all 27 residents of the memory care unit at immediate risk of harm.

Findings Included:

On , a review of Resident #1's records revealed that on , Resident #1 was found by staff members in the memory care courtyard of the facility, unresponsive with shaking arms and . The records revealed that staff called 911 and Emergency Management Service ( ) arrived and transported the resident to the hospital, where the resident was admitted to the ( ). Continued record review revealed that after a few days and a poor prognosis for recovery, the resident's family member consented to transporting Resident #1 to a hospice house, where the resident a few hours after arrival.

Review of a statement, dated Saturday , prepared by Staff E, a caregiver, revealed that Resident #1 was found by Staff E at approximately 3:40pm, sitting in the sun in the memory care courtyard, having what appeared to be and that Staff E pulled the chair where he was sitting into the shade, out of the sun and waited for help.

Review of a statement dated , prepared by Staff H, a caregiver, revealed that at 3:30pm, a memory care unit staff member, Staff G, walked to the front of the facility to get Staff H because the memory care staff were concerned that Resident #1 "didn't look right and appeared to be having a ". Staff H then went to the memory care unit to investigate and found Resident #1 was not responsive and was very warm to touch. Staff H also noticed that the resident's , arms, and torso

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were red in color. After approximately 15 minutes of trying to cool down the resident with cool cloths and sips of water, unsuccessfully, Staff H told the memory care unit staff to call to send the resident to the hospital for more immediate care. arrived at approximately 4:00pm and transported the resident to the hospital.

Review of a statement dated at 4:00pm, prepared by Staff D, a caregiver, revealed that after passing medications in the assisted living area of the facility, Staff D entered the memory care unit and saw the staff were out in the courtyard assisting Resident #1. Staff D noticed that the resident was shaky and , and noticed that his was pale. Staff D said the resident needed to go to the hospital. Staff D called the on-call nurse (the Director of Nursing or DON) and left a voice mail. Staff D also called Resident #1's family member. came and took Resident #1 to the hospital. Staff D reported that they placed a follow up call to the hospital around 8:15pm and the hospital nurse said Resident #1 had been admitted to . Continued record review revealed the hospital nurse asked how long the resident was sitting outside. Staff D told the hospital nurse the facility staff was not sure. Staff D then called the DON to update the DON about the resident's condition.

A review of the report revealed that when arrived to treat Resident #1, the resident's temperature was 106.9 degrees Fahrenheit. Resident #1was transported from the facility to a nearby hospital. Local temperatures on were a high of 92 degrees and a low of 72 degrees Fahrenheit.

Resident #1's hospital records were reviewed on (photographic evidence obtained). According to the hospital sheet, the resident's chief complaint was "unresponsive" and the admitting diagnosis was "heat , hyperpyrexia (a very hot body temperature)." The resident was brought into the Emergency Room (ER) by .

The hospital records revealed that the ER attending physician wrote in the "History of Present Illness" that on "apparently, the patient was found unresponsive and having shaking of and outside in the courtyard. Apparently, the patient (was) sitting in sun for unknown hours. The patient was found to be also agitated, restless time to time given in the emergency room to calm (the patient) down. The patient (was) noted to have a temperature of 107 degrees Fahrenheit, when (the patient) was first found outside at (the facility)."

The hospital records show that the ER attending physician wrote the following in the initial assessment of Resident #1 on :
1. Heat causing hyperpyrexia and changes in mental status and
(abnormalities of water, , and other chemicals that adversely affect function)

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2. Rule out neurologic (a life threatening reaction that occasionally occurs in response to medication)
3. Rule out (a life threatening complication of an)
4. Underlying medication like
5. History of
6. Underlying (a) or
7. Acute (comes on suddenly or rapidly) hypoxic (too little) and hypercapnic (too much) failure
8. Rule out as D-Dimer (a test to rule out an inappropriate clot) is only 150
9. Possible and .

Review of the hospital records revealed that the ER attending physician's plan for Resident #1 (the patient) included "the patient will be admitted as inpatient to the ( )", "need close monitoring and supportive ", "without hospitalization the patient is at risk for worsening , , and , ", "intense measures have been implemented to bring temperature down in the form of cooling blankets, ice- , and fluid , and the temperature was able to decrease below 99 within a few hours of admission".

The hospital records also revealed that on , the attending physician wrote a Final Diagnosis, upon discharge, as follows:
1. , ,
2. with a temperature of 107 degrees Fahrenheit
3. ,
4. ( ) exacerbation
5. Acute hypoxic and hypercapnic , failure
6. Underlying and and .

Per the hospital records, Resident #1 was discharged to a local hospice house on at 13:49 (1:49pm).

In an interview with Resident #1's family member at 12:45pm on , via telephone, the family member stated that the hospital doctor have given the patient a poor prognosis for recovery. The family member stated that Resident #1 on at the hospice house after being there for four hours.

According to Resident #1's Medication Observation Record (MOR) for , at 2:00pm the resident was given the medication 25 milligrams (MG) for the treatment of . Healthline.com indicates " can make you more sensitive to the sun. Keep out of the sun." Mayoclinic.org

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indicates " , may cause your skin to be more sensitive to sunlight than it is normally. Exposure to sunlight, even for brief periods of time, may cause a skin , itching, redness or other discoloration of the skin, or a severe sunburn."
At 12:00pm on , the MOR indicated that the resident received , , 1 MG tablet, for the treatment of side effects caused by long term use of , medications and , DR 125MG tablet to prevent . According to Resident #1's MORs, these medications were standing orders and were given as ordered. Staff F, a former staff member of the facility, signed off that the medications were given at 2:00pm and at 12:00pm on .

During an interview with the DON on at 5:20pm, the DON stated that the facility residents receive some type of drink at 10:00am and a scheduled snack and a drink at 2:00pm. In the memory care unit, the residents were all brought to the dining room for their drink and snack. There was no other written procedure or schedule for monitoring or documenting the whereabouts or condition of the residents.

A telephone interview was conducted with Staff F, a former employee of the facility on at 10:24am. Staff F confirmed being on duty on and confirmed giving Resident #1 medications around 2:30pm. Staff F was not certain where Resident #1 was when the medications were given, but Staff F believed the resident was outside. Staff F said the shift ended at 3:00pm and said Resident #1 was still outside when the staff member left at the end of the shift.

Staff G, a former employee of the facility, was interviewed via telephone on at 1:15pm. In Staff G's statement, Staff G said (the staff member) worked on and remembered seeing Staff F go outside and give Resident #1 medication with a glass of water. Staff G remembered noticing that Resident #1 "did not look well" around 3:30pm and went and got another staff person to assist in checking on the resident.

The records review revealed that there was no documentation prepared by the DON or the Administrator, both licensed practical nurses (LPNs) except for nursing progress notes, dated , in Resident #1's record that summarized the statements written by Staff D, Staff E and Staff H.

The DON stated in an interview on at 3:00pm, that a facility staff member called the DON at 3:45pm on to report that Resident #1 was taken to the hospital by . The DON was unable to say how long Resident #1 had been sitting outside before the facility staff saw that something seemed wrong.

A tour was conducted of the facility's memory care unit throughout the day on . The unit was

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secured by a locked door for both ingress and egress from the rest of the building and consisted of one hallway with resident rooms and a large living space that was used for activities and a dining room. There was a large expanse of windows from this space looking out over a large, fenced-in courtyard. The door leading to the courtyard from the memory care unit was unlocked and the residents were able to go out that door into the courtyard without asking or notifying staff. There was a wraparound porch with overhanging roof, under which there was a row of about 16 chairs for the residents to sit in and look out over the courtyard. Most of the chairs were faced looking out towards the courtyard, and away from the windows looking in. Within the courtyard, there were paved walking trails and a few large shade trees as well as bushes growing in the courtyard. On at 2:10pm there were 10 residents observed sitting in the row of chairs outside on the porch. There were no staff members observed outside with the memory care residents. From the inside of the memory care unit, the backs of the residents sitting outside looking out onto the courtyard were visible through the windows.

In an interview with the Administrator at 10:15am on , the Administrator stated that they did not report Resident #1's emergency hospitalization, nor the resident's subsequent to the Agency for Healthcare Administration (AHCA) because "honestly (they) did not know (they) was supposed to". At 11:39am on the Administrator again stated that the facility did not know they were supposed to complete a report for the incident and confirmed that an adverse incident report was not completed. The Administrator stated they thought another state agency that conducted an investigation of Resident #1's emergency hospitalization was going to inform AHCA about the incident after they visited the facility. The Administrator also indicated she would provide the facility's policy and procedure regarding incident reporting, but never provided it on .

An interview with staff of another state agency who also responded to the facility regarding the emergency hospitalization incident of Resident #1 was conducted via telephone at 3:05pm on . During the interview, the staff of the other state agency stated that they told the Administrator it was the facility's responsibility to contact AHCA about any adverse incidents that occur within the facility.

An interview was conducted on at 3:00pm with the Administrator and DON. In the interview, both the Administrator and DON confirmed that, at the time of survey more than two months after Resident #1's , the facility had no policies, systems or plans in place to provide oversight and ensure supervision and hydration of the facility residents going into the courtyard and to prevent a similar situation of a resident suffering adverse effects due to exposure to outside temperatures. After intervention by Agency staff during the survey, the facility reported they would be implementing a plan.

On the facility provided the records they retained on file for Resident #1 and a review of the records was conducted. The records revealed that Resident #1 was admitted to the facility on .

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The resident's sheet indicated that the resident was receiving hospice care. The only health assessment in the records was dated and it revealed that Resident #1 had special needs for the diagnoses of , ( ), , , , , , and general . The resident was also prescribed the medication , . The assessment indicated that the resident required daily oversight.

The review of Resident #1's records revealed minimal nursing progress notes from when the resident first moved to the facility in of 2017. Following admission, there was a long gap of more than 9 months until , the day the resident at the hospice house. On , the Administrator wrote notes summarizing the internal incident report statements by Staff members D, E and H (photographic evidence obtained). There was no documentation written specifically from the DON or the Administrator about what happened to Resident #1 on or thereafter and no documentation regarding any follow-up or investigation of the incident aside from the staff statements.

On , the totality of the records contained in the facility's chart for Resident #1, was the progress notes, the health care provider visit records (4), the initial health assessment, a copy of the medication observation records (MORs) for and and podiatrist visit reports (3).

A review of a faxed copy of a hospice care plan, which was faxed over to the facility on , revealed that the resident was under the care of hospice prior to until . There were no records of the hospice nursing visits found in Resident #1's records.

In an interview at 12:35pm on , the Administrator stated that the facility only charts progress notes "by incident" and further stated the facility did not have any notes regarding what happened to Resident #1 because they weren't written. The facility also did not have any documentation regarding follow-up or investigation of the incident that led to Resident #1's . The Administrator stated that the DON and the Administrator are the only ones to complete documentation on the residents.

Class I

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to ensure there was evidence of a negative ( ) examination documented on an annual basis for 2 (Administer and Staff B) out of 8 records reviewed.

Findings Included:

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Focused employee record review revealed Administrator a date of hire of and results dated . Upon further review, there was no evidence of an annual negative examination.

Focused employee record review revealed Staff B with a date of hire of and results dated . Upon further review, there was no evidence of an annual negative examination.

An interview was conducted with the Administrator on 11/14/2018 at 1:25pm. The Administrator reviewed the file and confirmed there was missing evidence of a negative examination for herself and Staff B.

Class III

0081 - Training - Staff In-Service - 58A-5.0191( ) FAC

Based on interview and record review, the facility failed to ensure staff received required staff in-service training within 30 days of employment, for staff who provide direct care to residents for 2 (Staff C and Staff E) of 8 employee records reviewed.

Findings included:

Employee record review revealed Staff C with a date of hire did not have proof of control training, elopement response training, incident reporting training, recognizing and reporting resident , neglect, and , or activities of daily living and behavioral needs training.

Employee record review revealed Staff E with a date of hire did not have proof of control training, elopement response training, incident reporting training, recognizing and reporting resident , neglect, and , or activities of daily living and behavioral needs training.

An interview was conducted on at 1:25pm with the Administrator. The Administrator confirmed there were no trainings in the file for Staff C.

An interview was conducted on at 4:30pm with the Administrator. The Administrator confirmed there were no trainings in the file for Staff E.

Class III

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0086 - Training - ADRD - 58A-5.0191(10) FAC

Based on record review and interview, the facility failed to ensure staff that worked in the facility's secure unit received or related (ADRD) Level I training within 3 months of hire for 1 (Staff E) of 8 records reviewed.

Findings Included:

Employee record review revealed Staff E with a date of hire did not have proof of ADRD Level I training in her employee file. Staff E was listed on the schedule as direct care staff, and worked in the facility's secure memory care unit.

An interview was conducted on at 4:30pm with the Administrator. The Administrator confirmed Staff E did not have the required ADRD Level I training.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview, the facility failed to ensure staff received valid training of required ( ) training, within 30 days of employment, for staff who provide direct care to residents for 2 (Staff C and Staff E) of 8 employee records reviewed.

Findings included:

Employee record review conducted on revealed Staff C with a date of hire did not have proof of required training for Staff C.

Employee record review conducted on revealed Staff E with a date of hire did not have proof of required training for Staff E.

An interview was conducted on at 1:25pm with the Administrator. The Administrator confirmed there were no trainings in the file for Staff C.

An interview was conducted on at 4:30pm with the Administrator. The Administrator confirmed there were no trainings in the file for Staff E.

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Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on records review and interviews, the facility failed to maintain a licensed hospice's interdisciplinary care plan, specifying the services being provided by hospice and those being provided by the facility, in the resident's file for 1 resident of 9 who received hospice services (Resident #1).

Findings Included:

A records review of Resident #1's record was conducted at the facility on . The resident's sheet document, dated , revealed that the resident was receiving hospice services upon admission to the facility (photographic evidence obtained). The resident's records did not contain any other records from the hospice providing services to Resident #1.

An interview with the Director of Nursing (DON) at the facility was conducted at 10:15am on and the DON was asked to provide the resident's hospice records. At 12:00pm on , the DON provided the agency with a copy of the resident's Hospice Plan of Care. At the top of the document, the date/time stamp at the top of the document said at 10:41:45am and the date/time received by fax at the facility on at 11:47am (photographic evidence obtained).

In an interview with the DON at 1:35pm on , the DON admitted that the facility did not have any of Resident #1's hospice records on file in the facility and that they phoned the hospice service on the morning of and requested for them to fax them over, after the agency requested the facility to provide the records.

Class III

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

Based on records review and interviews, the facility failed to provide an adverse incident report to the agency within 1 business day after the occurrence, and the results of the facility's full investigation of the incident to the agency within 15 days after the occurrence, for an incident involving the transfer of a resident to a facility providing more acute care due to the incident, which later resulted in the resident's .

Findings Included:

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On , a review of Resident #1's records revealed that on , Resident #1 was found by staff members in the memory care courtyard of the facility, unresponsive with shaking arms and . The records revealed that staff called 911 and Emergency Management Service ( ) arrived and transported the resident to the hospital, where the resident was admitted to the ( ). Continued record review revealed that after a few days and a poor prognosis for recovery, the resident's family member consented to transporting Resident #1 to a hospice house, where the resident a few hours after arrival.

Review of a statement, dated Saturday , prepared by Staff E, a caregiver, revealed that Resident #1 was found by Staff E at approximately 3:40pm, sitting in the sun in the memory care courtyard, having what appeared to be and that Staff E pulled the chair where he was sitting into the shade, out of the sun and waited for help.

Review of a statement dated , prepared by Staff H, a caregiver, revealed that at 3:30pm, a memory care unit staff member, Staff G, walked to the front of the facility to get Staff H because the memory care staff were concerned that Resident #1 "didn't look right and appeared to be having a ". Staff H then went to the memory care unit to investigate and found Resident #1 was not responsive and was very warm to touch. Staff H also noticed that the resident's , arms, and torso were red in color. After approximately 15 minutes of trying to cool down the resident with cool cloths and sips of water unsuccessfully, Staff H told the memory care unit staff to call to send the resident to the hospital for more immediate care. arrived at approximately 4:00pm and transported the resident to the hospital.

Review of a statement dated at 4:00pm, prepared by Staff D, a caregiver, revealed that after passing medications in the assisted living area of the facility, Staff D entered the memory care unit and saw the staff were out in the courtyard assisting Resident #1. Staff D noticed that the resident was shaky and , and noticed that his was pale. Staff D said the resident needed to go to hospital. Staff D called the on-call nurse (the Director of Nursing or DON) and left a voice mail. Staff D also called Resident #1's family member. came and took Resident #1 to the hospital. Staff D reported that they placed a follow up call to the hospital around 8:15pm and the hospital nurse said Resident #1 had been admitted to . Continued record review revealed the hospital nurse asked how long the resident was sitting outside. Staff D told the hospital nurse the facility staff was not sure. Staff D then called the DON to update the DON about the resident's condition.

Resident #1's hospital records were received and reviewed on (photographic evidence obtained). According to the hospital sheet, the resident's chief complaint was "unresponsive" and the admitting diagnosis was "heat , hyperpyrexia (a very hot body temperature). The hospital

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records reveal that the ER attending physician wrote in the "History of Present Illness" that on "apparently, the patient was found unresponsive and having shaking of and outside in the courtyard. Apparently, the patient (was) sitting in sun for unknown hours. The patient (was) noted to have a temperature of 107 degrees Fahrenheit, when (the patient) was first found outside at (the facility)."

The hospital records show that the patient was discharged to a local hospice house on at 13:49 (1:49pm).

In an interview with Resident #1's family member at 12:45pm on , via telephone, the family member stated that the hospital doctor have given the patient a poor prognosis for recovery. The family member stated that Resident #1 on at the hospice house after being there for only 4 hours.

In an interview with the Administrator at 10:15am on , the Administrator stated that they did not report Resident #1's emergency hospitalization, nor the resident's subsequent to the Agency for Healthcare Administration (AHCA) because "honestly (they) did not know (they) was supposed to". At 11:39am on the Administrator again stated that the facility did not know they were supposed to complete an Adverse Incident report for the incident and confirmed that an adverse incident was not completed. The Administrator stated they thought the other state agency that conducted an investigation of Resident #1's emergency hospitalization was going to inform AHCA about the incident after they came and completed their investigation. The Administrator indicated they would provide the facility's policy and procedure regarding adverse incidents, but never provided it on , later admitting they the facility had no such policy.

Another state agency investigated the incident with Resident #1 on , completing the investigation on (photographic evidence obtained), as confirmed in a phone interview with the investigator at 3:05pm on . During the interview with the other state agency investigator, the investigator stated that they told the Administrator it was the facility's responsibility to contact AHCA of any adverse incidents that occur within the facility.

Class III