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
	AL11932376	A. BUILDING: _____ B. WING _____	08/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLARIS SENIOR LIVING NORTH NAPLES	10949 PARNU STREET NAPLES, FL 34109

(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 off-hours complaint survey for complaint #2019012603 was conducted on at 12:20 p.m., at Solaris Senior Living North Naples, an assisted living facility in Naples, Florida. Complaint #2019012603 was substantiated at tag #s A0025, A0029, and A0165. The following is a description of the deficiencies.	A 000		
A 025	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must 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 shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 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) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the	A 025		

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A 025	Continued From page 1	A 025		

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 record review and staff interviews, the facility failed to ensure Resident #1 received the supervision necessary to meet her needs. Failure to provide adequate supervision lead to a that may have been prevented.

The findings included:

Solaris Healthcare Policies and Procedures
Memory Care and Assisted Living
Policy Title: Resident Care Standards - General Requirements. Policy # A0057 Effective date:

*The Facility shall provide care and services appropriate to the needs of residents.
*The Facility shall offer personal supervision as appropriate for each resident.
*The Facility will provide daily observation by

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A 025	Continued From page 2 designated staff of the activities of the resident while on the premises and daily awareness of the general health safety, and physical and emotional well-being of the individual. *The Facility shall offer personal supervision, as appropriate for each resident, including general awareness of the resident's whereabouts. During an interview on . . . . at 1:51 p.m., Registered Nurse (RN) Staff A said she does remember the incident on . . . . . around 1:35 p.m. She said Resident #1 was in the TV room at the time of the . and no caregiver was in the room because they were short staff that day. The housekeeper came and told her and the Memory Care Unit Manager Staff B the resident was on the floor. Then the Memory Care Unit Manager and Registered Nurse Staff A went to the TV room to assess the resident. She said Resident #1 was sitting in front of her wheelchair leaning to one side. She said Resident #1 was alert and denied being in , . Resident #1 had a small . . . . . above her . , . and small . . . . on her arm. On at 2:14 p.m., Memory Care Unit Manager Staff B said she was on duty the Sunday Resident #1 . She said the housekeeper came and told her and the RN Staff A the resident had , and they went in to look at her. The resident was sitting in front of her wheelchair on the floor in the TV room. She had an . . . . . on her forehead above her . , . and a on her arm. The caregiving staff were not in the room at the time of the . . Record review of hospital records after Resident #1 was sent to the emergency room for evaluation 3 days post- , documented Resident #1 had a at the facility and sustained a broken	A 025		

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A 025	Continued From page 3 . . , (an Odontoid Type II . . . . . - . . . . . , 2nd bone). Resident #1 was not a . . . . . for surgery and due to . . . . . would not leave a stabilizing collar on until healed so the resident was sent to hospice house and . . . 10 days post . Class II	A 025		
A 029	58A-5.0182(5) FAC 429.255(1)(b), 429.26 Resident Care - Nursing Services 58A-5.0182 (5) NURSING SERVICES. (a) Pursuant to section 429.255, F.S., the facility may employ or contract with a nurse to: 1. Take or supervise the taking of vital signs, 2. Manage pill-organizers and administer medications as described in rule 58A-5.0185, F.A.C., 3. Give prepackaged enemas pursuant to a physician's order; and, 4. Maintain nursing progress notes. (b) Pursuant to section 429.255(2), F.S., the nursing services listed in paragraph (a), may also be delivered in the facility by family members or friends of the resident provided the family member or friend does not receive compensation for such services. 429.255(1)(b), FS Use of personnel; emergency care.- (b) All staff in facilities licensed under this part shall exercise their professional responsibility to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's physician. However, the owner or administrator of the facility shall be responsible for determining that the	A 029		

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A 029	Continued From page 4 resident receiving services is appropriate for residence in the facility. (c) In an emergency situation, licensed personnel may carry out their professional duties pursuant to part I of chapter 464 until emergency medical personnel assume responsibility for care. (2) In facilities licensed to provide extended congregate care, persons under contract to the facility, facility staff, or volunteers, who are licensed according to part I of chapter 464, or those persons exempt under s. 464.022(1), or those persons certified as nursing assistants pursuant to part II of chapter 464, may also perform all duties within the scope of their license or certification, as approved by the facility administrator and pursuant to this part. 429.26 (3), FS (3) Persons licensed under part I of chapter 464 who are employed by or under contract with a facility shall, on a routine basis or at least monthly, perform a nursing assessment of the residents for whom they are providing nursing services ordered by a physician, except administration of medication, and shall document such assessment, including any substantial changes in a resident's status which may necessitate relocation to a nursing home, hospital, or specialized health care facility. Such records shall be maintained in the facility for inspection by the agency and shall be forwarded to the resident's case manager, if applicable. This Statute or Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure each resident received the proper assessments and monitoring necessary to meet the residents' needs for 3 (Residents #1, #2, and #3) of 3 residents reviewed in the memory care unit after with injury to the	A 029		

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A 029	Continued From page 5 . . . . The facility failed to monitor and document all significant issues for 1 (Resident #1) of 3 residents reviewed. The facility nursing staff failed to provide adequate reporting to the physician for Resident #1's increasing , issues in her . . . and until the 3rd day after the .	A 029		

The findings included:

Solaris Healthcare Policies and Procedures
Memory Care and Assisted Living
Policy Title: Resident Care Standards - General Requirements. Policy # A0057 Effective date:
. . . .

**The Facility shall provide care and services appropriate to the needs of residents.
*The Facility shall offer personal supervision as appropriate for each resident.
*The Facility with provide daily observation by designated staff of the activities of the resident while on the premises and daily awareness of the general health safety, and physical and emotional well-being of the individual.
*The Facility shall offer personal supervision, as appropriate for each resident, including general awareness of the resident's whereabouts.
*The Facility will contact the resident's health care provider and other appropriate party such as the resident's family, health care surrogate if resident exhibits a significant change.
*SIGNIFICANT CHANGE" means a sudden or major shift in behavior or . . . , or the deterioration in health status.
*The Facility will maintain a written record, updated as needed, of any significant changes, any illnesses which resulted in medical attention, major incidents or other changes which resulted in the use of additional services.
*Written documentation will be maintained in the

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A 029	Continued From page 6 resident's record that notes any apparent significant changes." Solaris Flow Record: The form reads: "This form should be completed at the following intervals for follow-up for that is unwitnessed or in which the is struck, or if the resident otherwise requires checks. Any change in resident condition requires a phone call to the primary care physician. Initial baseline followed by: Every 15 minutes times 8 Every 30 minutes times 4 Every 1 hour times 4 Every 4 hours times 4 then every 8 hours until a total of 72 hours has elapsed. Temperature, , and , are to be done. Pupil response, resident level of , resident response to stimuli, resident's speech ability and strength of , arms, and are to be documented in the time frames above." 1. On at 1:51 p.m., Registered Nurse (RN) Staff A said she does remember the incident on around 1:35 p.m. She said Resident #1 was in the TV room at the time of the and no caregiver was in the room because they were short staffed that day. The housekeeper came and told her and Memory Care Unit Manager Staff B the resident was on the floor. The memory care unit manager and RN Staff A went to the TV room to assess the resident. She said Resident #1 was sitting in front of her wheelchair leaning to one side. She said Resident #1 was alert and denied being in . Resident #1 had a small above her , and small on her arm. RN Staff A said she checked her vital signs then they put her in bed for a nap. RN Staff	A 029		

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A 029	Continued From page 7 A said she did not call the doctor after the because she did not see the resident as really hurt too bad. She said she made out a change in condition form and left it for the doctor to look at the next day. RN Staff A said she was never told about any protocol for a resident who and hit their . . . RN Staff A then said she returned to work on Tuesday 3 p.m.-11 p.m. shift, the resident continued to complain of . . and . . . , and she gave her , and it helped a little, not a lot. RN Staff A said she did not call the doctor because she had been told they would do an ., in the morning. On . . . . . at 2:14 p.m., Memory Care Unit Manager Staff B said she was on duty the Sunday Resident #1 . . . She said the housekeeper came and told her and RN Staff A the resident had . . . and they went in to look at her. Resident #1 was sitting in front of her wheelchair on the floor. She was able to move all extremities and she had an . Staff B came in Monday morning and Resident #1 was having more , and she was acting very . . . . . ., so she gave her a prescribed as needed (prn) . She couldn't remember if she did vital signs. Then on Wednesday she saw Resident #1 sitting at her table with her down and she was not eating or doing anything. Resident #1 said she was having sever , in her . . and . . . She was not herself. Then about 12:20 p.m., they called the doctor and sent her out. The Memory Care Unit Manager Staff B said the protocol after a when the resident hits their . . . is to start the . . . . . ., . . flow record. On . . . . . at 2:51 p.m., LPN, Staff C, said she was on duty Sunday , . . on the 3 p.m.-11 p.m. shift. She said she checked on Resident #1 when she first came on. She said the	A 029		

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A 029	Continued From page 8 resident said her and were hurting and she gave her . LPN Staff C said she does not know of any protocol for after a monitoring. She said she did not call the doctor about the in the resident's or after the . Record review of Resident #1's chart showed that vital signs, , and were done 4 times from the time of the on the day of the . No vital signs or any documentation were recorded the day after the . The resident was only given twice in the 4 days from to . No check was done or recorded as indicated. Record review of hospital records after Resident #1 was sent to the emergency room (ER) for evaluation 3 days post , documented Resident #1 had a at the facility and sustained a broken , (an Odontoid Type II - 2nd bone). Resident #1 was not a for surgery and due to would not leave a stabilizing collar on until healed, so Resident #1 was sent to hospice house and 10 days post . On at 3:12 p.m., the Administrator said she did not have any policy and procedure post in , but did have a policy titled: "Resident Care Standards - General Requirements". She agreed the flow record by Solaris is the guideline staff were supposed to use after a to monitor the resident, but the documentation was not done. The Administrator agreed there was a lack of assessment after the resident's . 2. On Resident #2 in her bathroom	A 029		

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A 029	Continued From page 9 and sustained a raised bluish bump on right side of her . Resident #2 said it hurt when rubbing the area. According to the facility monitoring after process, Resident #2 was not monitored according to protocol. Resident #2 was only documented on twice, once on the 1st day and once on the 2nd day. 3. On or about . . . , Resident #3 had an unwitnessed with injuries to her , upper , and . . . . . According to record review and facility monitoring policy and process Resident #3 was not monitored according to protocol. Class II	A 029		
A 165	429.23(&) FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in:	A 165		

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A 165	Continued From page 10 1. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident 's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) [illegible], neglect, or [illegible] must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall	A 165		

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A 165	Continued From page 11 determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. 58A-5.0241 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1) above, the facility must submit a full report within	A 165		

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A 165	Continued From page 12 15 days of the incident. The full report must be submitted pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to file 1-day adverse incident reports as required. The incident involved Resident #1 sustaining a in the facility with an injury to her and arm. Resident #1 continued to complain of and after the and was sent to the hospital due to the injuries. The findings included: Record review of hospital records after Resident #1 was sent to the emergency room for evaluation 3 days post , documented the resident had a at the facility and sustained a broken , (an Odontoid Type II - 2nd bone). Resident #1 was not a for surgery and due to would not leave a stabilizing collar on until healed, so the resident was sent to hospice house and 10 days post . On at 1:51 p.m., Registered Nurse (RN) Staff A said she remembered the incident on around 1:35 p.m. She said Resident #1 was in the TV room at the time of the and no caregiver was in the room because we were short staff that day. Resident #1 sustained an above her and small on her arm. Record review documented after Resident #1's on the resident started complaining of her and that continued until she was sent to the hospital on . On at 3:12 p.m., the Administrator said	A 165		

Agency for Health Care Administration

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLARIS SENIOR LIVING NORTH NAPLES	10949 PARNU STREET NAPLES, FL 34109

(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 165	Continued From page 13 she had not done an investigation or submitted an adverse incident report of the incident in a timely manner. She did not do an adverse incident report until an investigator from the Department of Children and Families (DCF) came in. She said she did not really see it as a reportable. Class III	A 165		