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
	AL11968551	A. BUILDING: _____ B. WING _____	09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS OF VENICE RETIREMENT RESIDENCE	2901 JACARANDA BLVD VENICE, FL 34293

(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 survey for complaint #2019014253 was conducted [redacted] through [redacted] at Gardens of Venice Retirement Residence, an assisted living facility in Venice, Florida. Complaint #2019014253 was substantiated at A0025, Class II. The following is description of the deficiency.	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 [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 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 interview, the facility failed to supervise 1 (Resident #1) of 4 residents reviewed, in a manner to maintain awareness of the resident's whereabouts. This failure resulted in the resident being hospitalized for exposure to the elements and insects outside the facility during nighttime hours. The findings included: The complaint alleged Resident #1 was missing from the facility for some time and was found lying on the ground under a hedge. Review of the Resident Sign-out Log showed Resident #1 signed out of the facility on at 9:50 a.m. without recorded signing in.	A 025		

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A 025	Continued From page 2 The Medication Observation Record (MOR) documented on Resident #1 received his 8:00 a.m. medications, his 5:00 p.m. medications, and his 7:00 p.m. medication. The MOR showed on Resident #1 did not take his 8:00 a.m. medications. Resident #1 is to have his checked each morning. The Tracker sheet for Resident #1 recorded and rate for Sunday through Saturday . The sheet showed the was not obtained on . The Caregiver Detail Duties 2nd Shift sheet listed to do rounds 4 times during the shift and other resident contact activities. The Caregiver Detail Duties 3rd Shift sheet included to ensure all residents are up and they are clean. In an interview on at 4:16 p.m., Med Tech (medication technician) Staff F said Resident #1 has evening medications scheduled for 5:00 p.m. and 7:00 p.m. Asked if evening medications are sometimes given at the same time, Staff F said Resident #1 wants to take them separately. Staff F said on she gave the 5:00 p.m. medications to Resident #1 at meal time. She said she was looking for Resident #1 and went by the library around 7:00 p.m. and saw a man who was either Resident #1 or another resident who has a similar look. Staff F said she went to the med cart and then to look for Resident #1. Staff F said she did not find him in the library so went in Resident #1's room but did not see him. She said she did not see Resident #1 after the 5:00 p.m. med pass. Staff F said she did not look for him after 7:00 p.m. She said Resident #1 was good about getting medications in the evening. Staff F said she did not know if Resident #1 was in the building on the evening of	A 025		

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A 025	Continued From page 3 . . . . . In an interview on . . . . at 4:03 p.m., Caregiver Staff D who worked 2:00 to 10:00 p.m. on , said she saw Resident #1 at dinner. Staff D said it is her practice to check residents at bed time. She said on Saturday . . . . she checked the door to Resident #1's room around 7:30 p.m. and found it was locked. Staff D said she knocked and waited but there was no answer. Resident #1 shares the room with Resident #2. Staff D said Resident #2 did not answer the door. She said she works second and third shift at the facility. She said she does rounds on her shift but did not have a key to the resident rooms, so could not check residents in rooms that were locked. Staff D said she did not know if Resident #1 was out of the building. Staff D said she was unsure of the elopement protocol. In an interview on . . . . at 3:06 p.m., Caregiver Staff C said she was working 2:00 p.m.-10:00 p.m. on . . . . . Staff C said did not see Resident #1 that evening. She said she usually sees him in the front lobby reading his books. Staff C said she was not responsible for Resident #1's hall. In an interview on at 5:35 a.m., Caregiver Staff E said she was working the 10:00 p.m.- 6:00 a.m. shift the night of - . Staff E said she does not check in on all residents on the 3rd shift. She said there are some residents she checks every two hours for . . . . . care. Staff E said most residents are sleeping and she does not disturb them. She said she did not check on Resident #1 the night of - . In an interview on at 11:44 a.m., Caregiver Staff B said she was getting her residents up around 7:30 a.m. on . Staff B	A 025		

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A 025	Continued From page 4 said she did not see Resident #1 in the morning on Sunday . She said every morning she goes through her hall and checks on those residents who are not up. Staff B said when she checked the room of Resident #1 and #2, Resident #2 was not out of bed, but Resident #1 was not in the room. Staff B said when Resident #1 did not show for his medications the Med Tech asked her to go check for Resident #1. Staff B told the Med Tech she had already checked his room and he was not there and that she had not seen him. In an interview on at 11:12 a.m., Supervisor Med Tech Staff A said she worked from 5:00 a.m. to 5:30 p.m. on and . Staff A said she served Resident #1 dinner in the dining room at 5:00 p.m. on and did not notice any signs or symptoms of ill health or unusual behavior. She said he seemed fine; he was pleasant and alert. Staff A said she arrived at the facility on at 5:00 a.m. She said she went to look for Resident #1 in his room at about 8:00 a.m. because he had missed his medications. Staff A said Resident #1 was not in his room and she did not make any further attempt at that time to locate him. Staff A said she presumed Resident #1 had left early for church. She said that around 8:30 a.m. a friend showed up to give Resident #1 a ride to church. Staff A said the friend went on to church and called to the facility to report that Resident #1 had not arrived at church. Staff A said she then initiated the elopement protocol. Review of the Resident Observation Log for Resident #1 revealed through the efforts of the caregivers, med techs, family, and emergency services a tracking device (which the facility did not have access) was activated, and Resident #1	A 025		

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A 025	Continued From page 5 was finally located at 12:30 p.m. on . Review of the Emergency Medical Services ( ) report on included Resident #1 was found "laying prone in a heavily wooded brush and bushy area. [Patient] appears to be in moderate distress, has no recollection of current events,... Physical assessment reveals a red pustules on right arm possibly from red ant bites that were pulled off [patient]... transported to [local hospital] without incident." Review of the local hospital Emergency Department (ED) Triage Assessment at 2:01 p.m. noted, "General: Appears ill, unkempt, dirty. Behavior is , , flat. General: Patient arrives with numerous bites to the upper and lower extremities, around the , dirt caked to the , and , to the lower extremities." The ED Assessment at 2:10 p.m. included "There are multiple open sores and scabbed areas to the , arms, , right , and lower extremities. There is an open to the right . Multiple bites to the and areas. There is and to the right and it shut at the time of arrival..." Resident #1 was admitted to the hospital. During an interview in the hospital on at 1:35 p.m., Resident #1 was communicative though drowsy with some . The resident was able to relate some details. The resident said he left the assisted living facility on when it was still light outside. The resident said he normally signs out when he leaves the building but does not remember if he signed out or which exit he used on that day. He said his purpose for leaving was to go to his condo in	A 025		

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A 025	Continued From page 6 town. Resident #1 said he does not remember why he wanted to go to the condo and does not remember if he made it there or not. The resident said, in returning to the facility, he was going around to the of the facility to get in. The resident said it was late and he cut through an open area with tall grass. Resident said he was pretty tired, so he sat down to rest and to get under the hedge by the fence. He said he does not remember anything else. In an interview on at 11:45 a.m., the Administrator, the Compliance Officer, and the Chief Operating Officer acknowledged that Resident #1 was admitted as an assisted living resident for services, , assistance with medications and daily , , . The management acknowledged they have a duty to supervise assisted living residents and provide the services for which they were . The facility staff failed to conduct rounds on Resident #1 and failed to locate the resident to assure medications and , were taken. The caregivers and med techs did not make an effort to assure Resident #1 was in the building from 5:00 p.m. on through 8:40 a.m. on . The facility staff were not aware of the resident's absence from the facility which resulted in harm to the resident. Class II	A 025		