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
	AL11968979	A. BUILDING: _____ B. WING _____	09/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACH HOUSE NAPLES ASSISTED LIVING & MEMOF	1000 AIRPORT PULLING RD S NAPLES, FL 34104

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A 000	Initial Comments An unannounced off-hours complaint survey for complaint #2019009522 was conducted on Saturday at 9:00 am at Beach House Naples Assisted Living and Memory Care, an assisted living facility in Naples, Florida. Complaint #2019009522 was substantiated at tag # A0025 and A0030. The following is 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		

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	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 observation, record review and staff interviews, the facility failed to provide adequate supervision to prevent the sunburn of 1 (Resident #1) of 3 residents reviewed in the memory care unit. The facility also failed to investigate the circumstances of the incident that lead to the resident sustaining the sunburn or to establish measures to prevent future residents from suffering the same fate. These systemic failures put Resident #1 and other residents at risk to be injured in the same way.

The findings included:

Review of resident records noted Resident #1 was an , female with with , , , , and . Resident #1 resided on the memory care unit in the facility and

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A 025	Continued From page 2 was also on hospice services since . . . . . Resident #1 was wheelchair bound. Review of the incident report dated documents Resident #1's . . . , . . , and . . . . were found to be red and reported as a . No further details were documented by facility nurse. On at 9:45 a.m., observed a large outdoor courtyard with 2 covered areas off the memory care unit. The covered porches had chairs, but no resident was seen outside at the time of the tour. The doors go going in and out to the courtyard had touch pads to open doors for residents in wheelchairs. It was undetermined if Resident #1 was able to exit or enter the courtyard on her own. Review of hospice communication documents the facility nurse contacted hospice on . . . . . to report that Resident #1 had a very red , ... and her . . . and . . . were running. The hospice nurse arrived at the facility and documented this assessment: Resident had localized bright red areas at mid thighs to , mid . . , bridge of . . . and left side of forehead. Areas were warm to touch. No streaking or . . . . . noted. The hospice nurse wrote that home health aide and the facility nurse said the resident had been outside for approximately 20 minutes. The nurse also contacted daughter in which she stated her mother is very sensitive to the sun. Record review of Resident #1's observation notes, written by the facility nurse, documented a late entry on at 9:45 p.m., that resident was noted to have redness to upper . . , . . . and lower arms. On the resident was	A 025		

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A 025	Continued From page 3 observed to have continued red [redacted] and [redacted]. The nurse reported the observation to hospice and the Director of Nursing (DON). On [redacted] the nurse documented the resident continued with redness to [redacted]/thighs, right [redacted], and [redacted]. The resident complained of [redacted] at the time and when asked about the reddened areas the resident responded, "It happened 3 days ago from sunburn." On [redacted] hospice crisis care was started per doctor's order and the resident declined and [redacted] on [redacted] at 4:40 p.m. On [redacted] at 10:12 a.m., in an interview with the Executive Director (ED), she said she was not the ED at the time of the incident and was unaware of the event until now. The ED said she was unaware of any facility policy for monitoring or observing residents in the courtyard for sun exposure or hydration. On [redacted] at 10:21 a.m., the Wellness Director said she also was not here at the time of the incident and did not know about it. She said she came to the facility the first week of [redacted]. She said she had no documentation of an investigation but was able to provide a form titled "ALF Major Incident Report". The Wellness Director said she was unaware of any policy or monitoring procedure used by staff to monitor residents in the courtyards. On [redacted] at 11:39 a.m., The Memory Care Manager said per phone conversation said she recalls the incident but thought it was an [redacted] reaction to a medication at first and did not remember any investigation being done on the incident. She said she believed that there was documentation of a staff meeting where they reviewed the policy and procedure of [redacted] and	A 025		

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A 025	Continued From page 4 Neglect and Exposure incident form with the facility safe a couple of weeks after the incident. On at 10:35 a.m., Memory Caregiver Staff A said she was aware of the incident, but she did not know who had taken the resident outside the day she got the sunburn. She said the resident was in a wheelchair and needed assistance to go in and out. She also said she does not recall anyone interviewing her about what she knew about the incident. On at 10:47 a.m., Medication Technician/Caregiver Staff B, in the memory unit said she was off when the incident happened but when she returned, she heard about it and had seen the on the resident. She said all she knew is the resident was outside and got a . She said she does not recall an investigation being done and she does not remember having a meeting or education about it. On at 12:30 p.m., the ED said she was unable to find any record of an investigation into the incident or the circumstances of how the resident got the sunburn. Class III	A 025		
A 030	58A-5.0182(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 58A-5.0182 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (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	A 030		

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A 030	Continued From page 5 Program must 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. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow 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. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements;	A 030		

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A 030	Continued From page 6 7. . . . . control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must 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 must allow 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 must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical . . . . . by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . 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,	A 030		

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A 030	Continued From page 7 free from . . . . . 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 pursue 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 attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with 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	A 030		

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A 030	Continued From page 8 at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are 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 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	A 030		

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A 030	Continued From page 9 special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, [illegible], and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and, if applicable, [illegible], Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident ' s access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and [illegible], Rights Florida. 429.27(1)(a), FS Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [illegible] or [illegible] under state law, managing his or her own affairs. (b) The admission of a resident to a facility and	A 030		

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A 030	Continued From page 10 his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a safe environment to prevent sunburn of 1 (Resident #1) of 3 residents reviewed in the memory care unit. The facility also failed to investigate the circumstances of the incident that lead to the resident sustaining the sunburn or take measures to prevent future residents from suffering the same fate. These systemic failures put Resident #1 and other residents at risk to be injured in the same way. The findings included: Review of resident records noted Resident #1 was an , female with with and . Resident #1 resided on the memory care unit in the facility and was also on hospice services since . Resident #1 was wheelchair bound. Review of the incident report dated documents Resident #1's , , and were found to be red and reported as a . No further details were documented by facility nurse.	A 030		

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A 030	Continued From page 11 On at 9:45 a.m., observed a large outdoor courtyard with 2 covered areas off the memory care unit. The covered porches had chairs, but no resident was seen outside at the time of the tour. The doors go going in and out to the courtyard had touch pads to open doors for residents in wheelchairs. It was undetermined if Resident #1 was able to exit or enter the courtyard on her own. Review of hospice communication documents the facility nurse contacted hospice on to report that Resident #1 had a very red , and her and were running. The hospice nurse arrived at the facility and documented this assessment: Resident had localized bright red areas at mid thighs to , mid , bridge of and left side of forehead. Areas were warm to touch. No streaking or noted. The hospice nurse wrote that home health aide and the facility nurse said the resident had been outside for approximately 20 minutes. The nurse also contacted daughter in which she stated her mother is very sensitive to the sun. Record review of Resident #1's observation notes, written by the facility nurse, documented a late entry on at 9:45 p.m., that resident was noted to have redness to upper , and lower arms. On the resident was observed to have continued red , and . The nurse reported the observation to hospice and the Director of Nursing (DON). On the nurse documented the resident continued with redness to /thighs, right , and . The resident complained of , at the time and when asked about the reddened areas the resident responded, "It	A 030		

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A 030	Continued From page 12 happened 3 days ago from sunburn." On hospice crisis care was started per doctor's order and the resident declined and on at 4:40 p.m. On at 10:12 a.m., in an interview with the Executive Director (ED), she said she was not the ED at the time of the incident and was unaware of the event until now. The ED said she was unaware of any facility policy for monitoring or observing residents in the courtyard for sun exposure or hydration. On at 10:21 a.m., the Wellness Director said she also was not here at the time of the incident and did not know about it. She said she came to the facility the first week of . She said she had no documentation of an investigation but was able to provide a form titled "ALF Major Incident Report". The Wellness Director said she was unaware of any policy or monitoring procedure used by staff to monitor residents in the courtyards. On at 11:39 a.m., The Memory Care Manager said per phone conversation said she recalls the incident but thought it was an reaction to a medication at first and did not remember any investigation being done on the incident. She said she believed that there was documentation of a staff meeting where they reviewed the policy and procedure of and Neglect and Exposure incident form with the facility safe a couple of weeks after the incident. On at 10:35 a.m., Memory Caregiver Staff A said she was aware of the incident, but she did not know who had taken the resident outside the day she got the sunburn. She said the resident was in a wheelchair and needed	A 030		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACH HOUSE NAPLES ASSISTED LIVING & MEMOF	1000 AIRPORT PULLING RD S NAPLES, FL 34104

(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 030	Continued From page 13 assistance to go in and out. She also said she does not recall anyone interviewing her about what she knew about the incident. On . . at 10:47 a.m., Medication Technician/Caregiver Staff B, in the memory unit said she was off when the incident happened but when she returned, she heard about it and had seen the . . . on the resident. She said all she knew is the resident was outside and got a . She said she does not recall an investigation being done and she does not remember having a meeting or education about it. On . . at 12:30 p.m., the ED said she was unable to find any record of an investigation into the incident or the circumstances of how the resident got the sunburn. Class III	A 030		