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 |
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| | AL11968942 | A. BUILDING: _____ B. WING _____ | 09/26/2019 |

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| THE FOUNTAINS OF HOPE | 2250 JESUS WAY SARASOTA, FL 34240 |

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| A 000 | Initial Comments<br><br>An unannounced complaint survey for complaint #2019014745 was conducted [redacted] through [redacted] at The Fountains of Hope, an assisted living facility located in Sarasota, Florida.<br><br>Complaint #2019014745 was substantiated at tag A0010, A0025, A0030 and A0081.<br><br>The following is a description of the deficiencies: | A 000 | | |
| A 010 | 429.26(1&9) FS; 58A-5.0181(4) FAC Admissions - Continued Residency<br><br>429.26<br>(1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.<br>(9) A [redacted], ill resident who no longer meets the criteria for continued residency may remain in | A 010 | | |

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| A 010 | Continued From page 1<br>the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met.<br><br>58A-5.0181<br>(4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a [illegible]-to-[illegible] medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are:<br>(a) The resident may be bedridden for no more than 7 consecutive days.<br>(b) A resident requiring care of a [illegible] may be retained provided that:<br>1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider,<br>2. The condition is documented in the resident's record; and,<br>3. If the resident's condition fails to improve within 30 days, as documented by a health care | A 010 | | |

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| A 010 | Continued From page 2<br><br>provider, the resident must be discharged from the facility.<br>(c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:<br>1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;<br>2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency;<br>3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and,<br>4. Documentation of the requirements of this paragraph is maintained in the resident's file.<br>(d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times.<br>(e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.<br>(f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.<br>(g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C.<br><br>This Statute or Rule is not met as evidenced by: | A 010 | | |

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| A 010 | Continued From page 3<br><br>Based on record review, observation and interview the facility failed to evaluate the appropriateness of continued residency for 3 (Resident #100, #102, and #104), out of a sample of 3 residents, demonstrating a significant change of condition and/or an incomplete/inaccurate admission assessment.<br><br>The findings included:<br><br>1. Record review for Resident #100 revealed an AHCA Form 1823 Resident Health Assessment, dated [redacted] stating " [redacted] Risk, Elopement Risk, [redacted] " and "No" is indicated for "pose a danger to self or others? (Consider any significant history of physically aggressive behavior.)." Also a checkmark indicates "Needs Assistance with Self Administration. This allows unlicensed staff to assist with oral and [redacted] medication."<br><br>Review of physician orders revealed that Resident #100 has an order (and is receiving) [redacted] ( [redacted] ) 0.5mg 3 times day as needed (prn) for [redacted]. This medication requires a licensed nurse for administration. In addition, Page 4 of 5 states "Attached meds" with no attachment evidenced, Page 5 of 5 of the assessment was not completed and the medical certification was incomplete with the lack of address/telephone number of the examiner.<br><br>Resident #100 was admitted to Hospice on [redacted] and has had 4 physical altercations with another resident between [redacted] through [redacted].<br><br>At 10:30 a.m. on [redacted], the Director of Memory Care acknowledged that the resident did not have a physician order for Administration of Medications and the Resident Health Assessment | A 010 | | |

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| A 010 | Continued From page 4<br><br>AHCA form 1823 was incomplete and inaccurate and requires a new assessment. In addition, her admission to Hospice and recent physical altercations with another resident also indicates the need for the completion of a new Resident Health Assessment.<br><br>2. Review of the medical record, for Resident #102, revealed an AHCA form 1823 Resident Health Assessment dated . The assessment identified independent for ambulation, does not pose a danger to self or others (consider any significant history of physically or , aggressive behavior) and does not require 24-hour nursing or , , care. In addition, a medication list was left blank on page 4 of 5. The assessment indicated an inaccurate order to provide "assistance with self administration of medication" rather than "needs medication administration" for prn (as necessary) medications. Review of physician orders and medication administration records revealed that Resident #102 is receiving , 0.5mg every 8 hours as needed for , . This medication requires a licensed nurse for administration.<br><br>Further review of the medical record revealed that the Resident #102 had 9 incidents, during the timeperiod through , relating to altercations with other residents, with and without injury.<br><br>Observation of Resident #102 on and revealed the resident frequently ambulating unsupervised and exiting double doors leading to an outside area and another wing of the locked unit. On at 3:30 p.m. the resident was observed entering Rm A19 and pushing a visitor. The visitor needed to escort the | A 010 | | |

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| A 010 | Continued From page 5<br><br>resident out of the room and close the door.<br><br>Upon interview, on . . . . . at 3:35 p.m., the daughter of Resident #100 said that Resident #102 comes into her mother's room all the time and has pulled her hair, pushes her and takes her belongings. "This has been happening since . One incident resulted in a scratch on my mother's arm. I have reported this to the Ombudsman and AHCA."<br><br>The facility failed to reassess Resident #102 for continued stay at the facility due to a change of condition and an inaccurate assessment.<br><br>3. Resident #104's medical record revealed an AHCA 1823 Resident Health Assessment, dated , that indicates Special Precautions of , Stand by Assist with Mobility/Cane/Rolling Walker, Assistance with Ambulation, and Evaluation/Treatment. The assessment's Page 4 of 5 states "See Attached" and had no attachment evidenced. The assessment indicated "Needs Assistance with Self Administration. This allow unlicensed staff to assist with oral and medication." Review of physician orders revealed as needed (prn) , 1 tab, every 6 hours, for over 170 and diastolic over 105. This medication requires a licensed nurse for administration and a physician order indicating "Needs Medication Administration." In addition, no is recorded every 6 hours to evaluate the need for use of the .<br><br>Record review also revealed that the resident has experienced 9 , from to , 4 with injuries.<br><br>The facility failed to reassess Resident #104 for | A 010 | | |

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| A 010 | Continued From page 6<br><br>continued stay at the facility due to a change of condition and an inaccurate assessment.<br><br>Class III | A 010 | | |
| A 025 | 429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision<br><br>429.26<br>(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.<br><br>58A-5.0182<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:<br>(a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C.<br>(b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident.<br>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. | A 025 | | |

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| A 025 | Continued From page 7<br><br>(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.<br>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review, observation and interview, the facility failed to provide care and services appropriate for the needs of 3 (Resident #102, #103, and #104) out of a sample of 3 residents, accepted for admission to the Memory Care Unit that provides care.<br><br>The findings included:<br><br>1. Review of Resident #102's medical record revealed the following incidents:<br>threw her utensils across the table almost hitting another resident.<br>blocked the door and would not leave while inside of another resident's room with their family member.<br>found resident trying to pull another resident in a wheel chair out of their room.<br>involved in a physical altercation with another resident.<br>involved in a physical altercation with another resident.<br>involved in a physical altercation with another resident. | A 025 | | |

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| A 025 | Continued From page 8<br>. . . . . involved in a physical altercation with another resident, both residents laying on floor screaming and hitting each other.<br>involved in a physical altercation with another resident.<br>involved in a physical altercation with another resident.<br>There was no documented evidence there were plans developed and implemented to prevent the reoccurrence of the 9 foregoing events.<br><br>Further review of Resident #102's medical record revealed a nurse's progress note dated . . . . stating: Spoke with the Advanced Registered Nurse Practitioner (ARNP) about increased behaviors and aggression. The ARNP said, "I'm going to try adjusting her medications before ordering a psy consult."<br><br>A Resident Health Assessment AHCA form 1823 dated . . . . . stated the resident is independent with ambulation and is an elopement risk.<br><br>During an interview on at 10:15 a.m., Licensed Practical Nurse (LPN) Staff AA said Resident #102 has had frequent physical altercations with other residents. When asked what was being done to prevent reoccurrence, she said a , . . . . . nurse consultant referral was made and was completed , but they have not received the results of the consult yet. LPN Staff AA said the staff intervenes, but you just need to know how to approach Resident #102. When asked if the staff has had any recent training regarding . . . . . and neglect, resident rights or dealing with behavioral issues on a Memory Care Unit, she said she did not know of any. LPN Staff AA also acknowledged Resident #102 leaves Unit A and walks independently to Unit B, a screened in porch and an enclosed | A 025 | | |

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| A 025 | Continued From page 9<br>outside area without supervision.<br><br>Resident #102 was observed on [redacted] walking from Unit A to Unit B without supervision after the noon meal. Resident #102 was observed on [redacted] at 3:30 p.m., entering Room A19 (Unit A). The resident pushed a visitor (in room) out of the way to get in. The visitor was heard to tell Resident #102 "No, no", and was observed helping the resident out of the room.<br><br>Resident #102 was observed, on [redacted] at 10:15 a.m., walking from Unit A to Unit B without supervision when many resident's were attending an activity program on Unit A.<br><br>During an interview on [redacted] at 12:30 p.m., the Supervisor of the Memory Care Unit acknowledged that Resident #102 walked unsupervised, entered other resident rooms unsupervised, and left Unit A unsupervised. She also acknowledged a [redacted] consult was completed but the facility had not received the results or any recommendations at this time.<br><br>2. Review of Resident #103's medical record revealed he [redacted] unsupervised from the Memory Care B Unit to Resident #7's room on the Memory Care A Unit at 4:00 p.m., on [redacted]. An Incident Entry form stated "Heard yelling Help, Help. Found resident standing in hallway next to another resident by her apartment door. Resident unable to state what happened. Easily redirected away from the other resident. Refused vital signs. No apparent injury."<br><br>Review of Resident #7 's medical record revealed she was found sitting on the hallway floor by her apartment door on [redacted] at 4:00 p.m. The resident stated, per Incident Entry form, "I was | A 025 | | |

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| A 025 | Continued From page 10<br><br>trying to go into my room to lie down, noticed that man came by wanting to go with me in my room. I told him no, that's when he pushed me and I against the wall handrail, down I went." It was noted that the resident sustained small . on right and left .<br><br>During an interview on at 12:00 p.m., Resident #7 was asked if anyone ever harmed her. She said "Yes, there is a man who lives here that shoved me against the wall and hurt my , . He pushed me twice. I stay away from him and he goes outside a lot, thank God. I don't even want to think about it."<br><br>Resident #10, who resides on the Memory Care B Unit, was interviewed on at 3:00 p.m. When asked if he ever had a complaint, he said "Yes, I don't like people walking into my room. I don't walk into theirs. They are trying to prevent that from happening, but it still does."<br><br>Upon interview on at 2:30 p.m., Resident #101's son stated, "I am uncomfortable about my mother's room. A resident named '___' (Resident #103) comes over here (from B wing) and passes by her room all the time. He's a big guy and I know he pushes residents around."<br><br>Further medical record review revealed Resident #103 had a verbal and physical altercation with another resident when he tried to enter the resident's room. This occurred on with no injury. On at 4:00 a.m., a progress note documented that Resident #103 had increased , and was not sleeping well. The resident was , into other resident rooms.<br><br>Observation of Resident #103 on and | A 025 | | |

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| A 025 | Continued From page 11<br>. . . . . revealed that he ambulates independently from B wing to A wing without supervision. He primarily enters from the door in the hall near Room A19.<br><br>3. Review of the medical record for Resident #104 revealed she experienced 9 . , 4 with injury during the time period through . . . . . Further review of the medical record revealed there were no plans developed/implemented/evaluated to prevent reoccurrence of . A Resident Health Assessment AHCA 1823 dated . . . . , states she requires with ambulation, transfer and toileting and identified special precautions.<br><br>During an interview on at 1:00 p.m., the Supervisor of the Memory Care Unit acknowledged there were no plans to prevent reoccurrence of . . except for a , . . . , , consult. There was no documented evidence any safety measures were in place or that any investigation was conducted to ascertain how the . . occurred.<br><br>Class II | A 025 | | |
| A 030 | 58A-5.0182(6) FAC; 429.28( .) FS 429.27 Resident Care - Rights & Facility Procedures<br><br>58A-5.0182<br>(6) RESIDENT RIGHTS AND FACILITY PROCEDURES.<br>(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 Program must be posted in full view in a freely accessible resident area, and included in the | A 030 | | |

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| A 030 | Continued From page 12<br>admission package provided pursuant to rule 58A-5.0181, F.A.C.<br>(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.<br>(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.<br>(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:<br>1. Resident responsibilities;<br>2. and tobacco use;<br>3. Medication storage;<br>4. Resident elopement;<br>5. Reporting resident , neglect, and ;<br>6. Administrative and housekeeping schedules and requirements;<br>7. control, sanitation, and universal precautions; and, | A 030 | | |

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| A 030 | Continued From page 13<br><br>8. The requirements for coordinating the delivery of services to residents by third party providers.<br>(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.<br>(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.<br>(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 . .<br><br>429.28 Resident bill of rights.-<br>(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:<br>(a) Live in a safe and decent living environment, free from and neglect.<br>(b) Be treated with consideration and respect and | A 030 | | |

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| A 030 | Continued From page 14<br>with due recognition of personal dignity, individuality, and the need for privacy.<br>(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.<br>(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.<br>(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.<br>(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.<br>(g) Share a room with his or her spouse if both are residents of the facility.<br>(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.<br>(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. | A 030 | | |

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| A 030 | Continued From page 15<br>(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.<br>(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.<br>(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 special interest groups.<br>(2) The administrator of a facility shall ensure that | A 030 | | |

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| A 030 | Continued From page 16<br><br>a written notice of the rights, , 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 Hotline operated by the Department of Children and Families, and, if applicable, , 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 Hotline operated by the Department of Children and Families, and , Rights Florida.<br><br>429.27(1)(a), FS<br>Property and personal affairs of residents.-<br>(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 or under state law, managing his or her own affairs.<br>(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or | A 030 | | |

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| A 030 | Continued From page 17<br><br>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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review, observation and interview, the facility failed to ensure that 5 (Resident #100, #102, #103, #104, and #7), out of a sample of 5 residents, received adequate and appropriate health care consistent with established and recognized standards within the community. These standards include a safe living environment, free from [redacted] and neglect, for residents with a diagnosis of [redacted] and includes the development, implementation and evaluation of plans to prevent the reoccurrence of [redacted] and verbal/physical altercations.<br><br>The findings included:<br><br>1. Review of the medical record for Resident #100 revealed documentation of a physical altercation with another resident on [redacted] and [redacted].<br><br>During an interview on [redacted] at 3:35 p.m., Resident #100's daughter said that on Resident #101 tried to take a wheelchair from her mother and her mother scratched the resident as she tried to push her away. The daughter also said that Resident #101 grabbed her mother's | A 030 | | |

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| A 030 | Continued From page 18<br><br>hair while she was sleeping on . . . . . (as reported by the night nurse) and tried to enter her mother's room on . . . . . at 6:00 p.m. when she (daughter) was visiting. On the daughter said she witnessed Resident #101, in the dining room, trying to wrestled away a doll that her mother was holding in her arms. It took 2 staff members to intervene resulting in her mother having to let go of her doll because Resident #101 would not let go of it.<br><br>Review of Hospice documentation, for Resident #100 dated . . . . . , revealed the following registered nurse progress note: "Facility staff and daughter notified this writer that '___' (Resident #101) had another incident where another resident was found in her room grabbing onto '___' (Resident #101's) hair. Facility broke up the incident with no injuries occurring. This is the third incident with this resident."<br><br>2. Review of Resident #102's medical record revealed the following incidents:<br>threw her utensils across the table almost hitting another resident.<br>blocked the door and would not leave while inside of another resident's room with their family member.<br>. . . . . found resident trying to pull another resident, in a wheel chair, out of their room.<br>. . . . involved in a physical altercation with another resident.<br>. . . . involved in a physical altercation with another resident.<br>. . . . . involved in a physical altercation with another resident.<br>. . . . . involved in a physical altercation with another resident, both residents laying on floor screaming and hitting each other.<br>involved in a physical altercation with | A 030 | | |

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| A 030 | Continued From page 19<br><br>another resident.<br>involved in a physical altercation with another resident.<br>There was no documented evidence there were plans developed and implemented to prevent reoccurrence of the 9 foregoing events.<br><br>Further review of Resident #102's medical record revealed a nurse's progress note, dated . . . . , stating "Spoke with Advanced Registered Nurse Practitioner (ARNP) about increased behaviors and aggression. ARNP states 'I'm going to try adjusting her medications before ordering a psy consult'."<br><br>A Resident Health Assessment AHCA form 1823 dated . . . . . states the resident is independent with ambulation and is an elopement risk.<br><br>During an interview on at 10:15 p.m., Licensed Practical Nurse (LPN) Staff AA said Resident #102 has had frequent physical altercations with other residents. When asked what is being done to prevent reoccurrence, she said a , . . , . . . . . nurse consultant referral was made and was completed , but they have not received the results of the consult yet. LPN Staff AA said the staff intervenes, but you just need to know how to approach Resident #102. When asked if the staff has had any recent training regarding . . . . . and neglect, resident rights, or dealing with behavioral issues on a Memory Care Unit, she said she did not know of any. LPN Staff AA also acknowledged that Resident #102 leaves Unit A and walks independently to Unit B, a screened in porch and an enclosed outside area without supervision.<br><br>Resident #102 was observed on walking from Unit A to Unit B without supervision, after the | A 030 | | |

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| A 030 | Continued From page 20<br><br>noon meal. Resident #102 was observed at 3:30 p.m. entering Room A19 (Unit A) and pushed a visitor (in room) out of the way to get in. The visitor was heard to tell Resident #102 "No, no", and was observed helping the resident out of the room.<br><br>Resident #102 was observed, on at 10:15 a.m., walking from Unit A to Unit B without supervision when many resident's were attending an activity program on Unit A.<br><br>During an interview on at 12:30 p.m., the Supervisor of the Memory Care Unit acknowledged that Resident #102 walked unsupervised, entered other resident rooms unsupervised and left Unit A unsupervised. She also acknowledged that a , , consult was completed but the facility had not received the results or any recommendations at this time.<br><br>3. Review of Resident #103's medical record revealed he unsupervised from the Memory Care B Unit to Resident #7's room on the Memory Care A Unit at 4:00 p.m. on . An Incident Entry form stated "Heard yelling Help, Help. Found resident standing in hallway next to another resident by her apartment door. Resident unable to state what happened. Easily redirected away from the other resident. Refused vital signs. No apparent injury."<br><br>Review of Resident #7 's medical record revealed she was found sitting on the hallway floor by her apartment door on at 4:00 p.m. The resident stated, per Incident Entry form, "I was trying to go into my room to lie down, noticed that man came by wanting to go with me in my room. I told him no, that's when he pushed me and I against the wall handrail, down I went." It was | A 030 | | |

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| A 030 | Continued From page 21<br><br>noted that the resident sustained small . . . on right and left .<br><br>During an interview on at 12:00 p.m., Resident #7 was asked if anyone every harmed her. She said "Yes, there is a man who lives here that shoved me against the wall and hurt my , . He pushed me twice. I stay away from him and he goes outside a lot, thank God. I don't even want to think about it."<br><br>Resident #10, who resides on the Memory Care B Unit, was interviewed on . . . . . at 3:00 p.m. When asked if he ever had a complaint, he said "Yes, I don't like people walking into my room. I don't walk into theirs. They are trying to prevent that from happening, but it still does."<br><br>During an interview on . . . . . at 2:30 p.m., Resident #101's son stated, "I am uncomfortable about my mother's room. A resident named ' ', (Resident #103) comes over here (from B wing) and passes by her room all the time. He's a big guy and I know he pushes residents around.<br><br>Further medical record review revealed that Resident #103 had a verbal and physical altercation with another resident when he tried to enter the resident's room. This occurred on with no injury. On at 4:00 a.m., a progress note documented that Resident #103 had increased and was not sleeping well. The resident was . . . . into other resident's rooms.<br><br>Observation of Resident #103 on and . . . . . revealed that he ambulates independently from B wing to A wing without supervision. He primarily enters from the door in the hall near Room A19. | A 030 | | |

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| A 030 | Continued From page 22<br><br>4. Review of the medical record for Resident #104 revealed she experienced 9 . , 4 with injury, during the time period through . . . . Further review of the medical record revealed that there were no plans developed/implemented/evaluated to prevent reoccurrence of . A Resident Health Assessment, AHCA 1823, dated . . . . , status she requires with ambulation, transfer and toileting and identified special precautions.<br><br>During an interview on at 1:00 p.m., the Supervisor of the Memory Care Unit acknowledged that there were no plans to prevent reoccurrence of except for a , , . . . , , consult. There was no documented evidence that any safety measures were in place or that any investigation was conducted to ascertain how the . . occurred.<br><br>5. Review of the medical record for Resident #7 revealed that the resident injured another resident during a physical altercation on . . . . . and Resident #7 was found on the floor on after a physical altercation with another resident. Further review of the medical record revealed no documented evidence that plans were developed/implemented/evaluated to prevent physical altercations with other residents.<br><br>Class II | A 030 | | |
| A 081 | 58A-5.0191( ) FAC Training - Staff In-Service<br><br>(2) STAFF PRESERVICE ORIENTATION.<br>(a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted | A 081 | | |

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| A 081 | Continued From page 23<br><br>living facility employees who have not previously completed core training as detailed in subsection (1).<br>(b) New staff must complete the preservice orientation prior to interacting with residents.<br>(c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record.<br>(d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover:<br>1. Resident's rights; and,<br>2. The facility's license type and services offered by the facility.<br><br>(3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:<br>(a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement.<br>(b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: | A 081 | | |

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| A 081 | Continued From page 24<br>1. Reporting adverse incidents.<br>2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.<br>(c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:<br>1. Resident rights in an assisted living facility.<br>2. Recognizing and reporting resident . . . . ., neglect, and , . The facility must use its . . . . . prevention policies and procedures when offering this training.<br>(d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects:<br>1. Resident behavior and needs.<br>2. Providing assistance with the activities of daily living.<br>(e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices.<br>(f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment.<br>1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures.<br>2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. | A 081 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968942 | A. BUILDING: _____ B. WING _____ | 09/26/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE FOUNTAINS OF HOPE | 2250 JESUS WAY SARASOTA, FL 34240 |

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|---|---|---|---|---|
| A 081 | Continued From page 25<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure that 4 (Staff A, B, J, and M), out of a sample of 9 direct care employees, received required training related to resident rights in an assisted living facility (ALF) or Memory Care Unit (MCU) and recognizing/reporting resident . . . . ., neglect, and , .<br><br>The finding included:<br><br>Licensed Practical Nurse (LPN) Staff A working in the ALF, with date of hire (DOH) of . . . . ., had no documented evidence of completion of training in Resident Rights or . . . . ., Neglect and , .<br><br>Resident Aide/Medication Technician Staff B working in the ALF, with DOH of . . . . ., had no documented evidence of completion of training in Resident Rights or . . . . ., Neglect and , .<br><br>Resident Aide Staff J in the MCU, with DOH of . . . . ., had no documented evidence of completion of training in Resident Rights or . . . . ., Neglect and , . . . . . .<br><br>Resident Aide Staff M, with DOH of . . . . . ., has no documented evidence of completion of training in Resident Rights or . . . . ., Neglect and , .<br><br>During an interview on at 4:30 p.m., the Business Office Director acknowledged that Staff A, B, J, and M did not have required training in Resident Rights and . . . . ., Neglect and , . . . . | A 081 | | |

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 |
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|---|---|---|---|---|
| A 081 | Continued From page 26<br><br>Class III | A 081 | | |