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
	AL11969036	A. BUILDING: _____ B. WING _____	10/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHERIDAN AT LAKEWOOD RANCH	11705 EVENING WALK DR BRADENTON, FL 34211

(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 A Complaint Investigation (Complaint Number: 2019011864 and 2019012027) was conducted at Sheridan at Lakewood Ranch Assisted Living Facility on . . Deficiencies were identified at the time of survey.	A 000		
A 054 SS=D	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the	A 054		

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A 054	Continued From page 1 medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to immediately update Medication Observation Records (MORs) each time a medication was offered to two Residents (#1 and #3) of three sampled resident that required assistance with self-administration of medications. Findings Included: A review of Resident #1's MORs, conducted on , revealed that Resident #1 had prescribed medications not signed as given or offered to the resident, which included: - , , 5mg was not documented as given to Resident #1 on and at 08:00pm - , 0.5mg was not documented as given to Resident #1 on at 08:00pm - , 25mg was not documented as given to Resident #1 on and at 05:00pm There was no documentation as to the reason that Resident #1 did not receive the medications in the resident's record. There were no orders to hold Resident #1's medications in the resident's record. Resident #1's most recent undated Health Assessment Form stated that the resident required assistance with self-administration of medications. A review of Resident #3's MORs, conducted on , revealed that Resident #3 had a prescribed medication not signed as given or offered to the resident, which included , 125mg was not documented as given to the resident on and at	A 054		

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A 054	Continued From page 2 04:00pm. There was no documentation as to the reason that the resident did not receive the medication in the resident's record. There was no order to hold Resident #3's medication in the resident's record. Resident #3's most recent Health Assessment Form dated stated that the resident required assistance with self-administration of medications. During an interview with Administrator and Director of Nursing, conducted on , both agreed that that Resident #1 and #3 had medications that were not documented as given to the residents on the resident's MORs. Class III	A 054		
A 162 SS=D	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name; 2. ; 3. Race; 4. Date of birth; 5. Place of birth, if known; 6. Social security number; 7. Medicaid and/or Medicare number, or name of other health insurance ; 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in Rule	A 162		

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A 162	Continued From page 3 58A-5.0181, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [illegible], or other services to be provided, supervised, or implemented by the facility that require a health care provider ' s order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 58A-5.020, F.A.C., if applicable. (e) The resident care record described in paragraph 58A-5.0182(1)(e), F.A.C. (f) A ⌄ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌄ recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 58A-5.025, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly	A 162		

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A 162	Continued From page 4 written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an . . . recipient, a copy of the Department of Children and Families form Alternate Care Certification for , ... , , ( ), CF-ES 1006, . . . , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 58A-5.0181, F.A.C. (o) The resident ' s , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required in this paragraph; 3. The health assessment described in Rule 58A-5.0181, F.A.C.; 4. The resident's contract described in Rule	A 162		

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A 162	Continued From page 5 58A-5.025, F.A.C.; and 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to obtain -to- health assessments documented completely on the required Agency for Health Care Administration Form 1823 ( ) and failed to follow their policy and procedure to update residents' Service Plans upon move-in, yearly, and with any changes in condition and with each for four Residents (#1, #3, #5, and #10) of four sampled residents that incurred frequent and had changes in conditions. Findings Included: A record review for Resident #1, conducted on , revealed that Resident #1's Health Assessment Form was not dated, was not on the required Form, did not have an elopement risk assessment, and did not include services offered or arranged for the resident's	A 162		

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A 162	Continued From page 6 identified needs on page five. Resident #1's Health Assessment was documented on the . . . . . Form. Resident #1 did not have an initial or any other Service Plan as required by the Facility's policy and procedure upon move-in. Resident #1's record did not include a Risk Tool Form per the Facility's policy and procedure. Resident #1 was admitted to the Facility on . . . . . . A record review for Resident #3, conducted on , revealed that Resident #3's Health Assessment Form dated . . . . . , was not on the required Form, did not have an elopement risk assessment, and did not include services offered or arranged for the resident's identified needs on page five. Resident #3's Health Assessment was documented on the . . . . . Form. Resident #3's initial Service plan was updated on . However, the Service Plan was not updated according to the Facility's policy and procedure with each that the resident sustained. Resident #3 incurred . . on , , , , , ... , ... , and . Resident #3's record did not include a Risk Tool Form per the Facility's policy and procedure. Resident #3 was admitted to the Facility on . . . . . . The Facility did not obtain a new -to- health assessment when Resident #3 had a significant decline in condition that necessitated the resident's admission into Hospice services on . . . . . . A record review for Resident #5, conducted on , revealed that Resident #5's Health Assessment Form dated . . . . . , was not on the required Form, did not have an elopement risk assessment, and did not include services offered or arranged for the resident's	A 162		

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A 162	Continued From page 7 identified needs on page five. Resident #5's Health Assessment was documented on the [illegible] Form. Resident #5's initial Services plan was dated [illegible] and was not updated according to the Facility's policy and procedure with each [illegible] that the resident sustained. Resident #5 incurred [illegible] on [illegible], and [illegible]. Resident #5's record did not include a [illegible] Risk Tool Form per the Facility's policy and procedure. Resident #5 was admitted to the Facility on [illegible]. A record review for Resident #10, conducted on [illegible], revealed that Resident #10's Health Assessment Form dated [illegible], was not on the required [illegible] Form, did not include services offered or arranged for the resident's identified needs on page five. Resident #10's Health Assessment was documented on the [illegible] Form. Resident #10's initial Services plan was dated [illegible] and was not updated according to the Facility's policy and procedure with each [illegible] that the resident sustained. Resident #10 incurred [illegible] on [illegible], and [illegible]. Resident #10's record did not include a [illegible] Risk Tool Form per the Facility's policy and procedure. Resident #10 was admitted to the Facility on [illegible]. A review of the Facility's [illegible] Management Program, conducted on [illegible], revealed that the Facility [illegible] Management Program had many components, which included: 1. That all new residents will be evaluated for [illegible] and [illegible] risk 2. Individualized Service Plan development 3. The Health and Wellness Director will complete the [illegible] Risk Tool form within 24-hours	A 162		

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A 162	Continued From page 8 after resident's move-in, a minimum of every six months, with significant condition changes, and after each . 4. A Resident who scores a 12 or higher will be considered "at risk for . . ." and their status and interventions will be addressed on [the resident's] Service Plan 5. A . Risk Tool form will be completed in conjunction with the Assessment and after each 6. If a resident has a . , or continues to have . , the Individualized Service Plan will be updated with new interventions after each . and immediately following a . , the Temporary Service Plan should be initiated by staff and upon investigation completion, the Health and Wellness Director will resolve the . Temporary Service Plan and update the current Individualized Service Plan with ongoing interventions to reduce . . During an interview with the Health and Wellness Director, conducted on . . . . at 05:00pm, the Health and Wellness Director stated that "Service Plans are updated quarterly and with changes in condition". At 05:15pm, the Administrator and the Health and Wellness Director agreed that the Facility was not following their policy and procedure with updating residents' Service Plans and documenting a Tool Assessment with each . occurrence according to their policy and procedures. Both stated that they were unaware that there was a required . . . . . Health Assessment Form 1823. Class III	A 162		