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
	AL11964952	A. BUILDING: ______ B. WING ______	**08/12/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF SARASOTA	**5509 SWIFT ROAD SARASOTA, FL 34231**

(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)	(X6) COMPLETE DATE
A 000	Initial Comments An unannounced complaint survey #2021011172 was conducted on at Arden Courts of Sarasota, an assisted living facility in Sarasota, Florida. Complaint # 2021011172 had 2 allegations both of which were substantiated. The following is a description of the deficiencies: .	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall 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 must notify the resident ' s representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents	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		

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 59A-36.012, F.A.C.
(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.
(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 interviews, and record reviews, the facility failed to provide adequate supervision and documentation to ensure the safety and needs were met and failed to document in the resident record for 1 (Resident #1) of 8 residents on Berryridge unit

The findings included:

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A 025	Continued From page 2 Record review revealed Resident #1 was admitted to the facility on with diagnosis including (rapid rate with poor flow), essential (high), , and (rapid heartbeat out of proportion to activity). No caregiver or nurse notes were present in Resident #1's record after . A ( ) form was completed on . A review of the Resident Health Assessment Form 1823 dated noted the resident was independent with walking, , eating, self care (grooming), toileting and transfer, and only needed assistance with bathing. An undated Resident Health Assessment Form 1823 dated revealed Resident 31 was still independent in ambulation, toileting and transfer. Interview on at 8:57 a.m., the Executive Director (ED) said she was at the facility on when the missing resident incident occurred. She had received a call at 11:05 p.m. from agency LPN at the change of shift. The ED said the caregivers did rounds and found Resident #1 not in her room. Agency CNA Staff B and agency LPN searched the courtyard, while the other caregivers searched house. Agency Staff B found Resident #1 down with her arms underneath her, called out to agency LPN and rolled her over to assess. Agency LPN called 911. Agency CNA Staff B stayed with the resident doing ( ) while agency LPN went to find the ( ) status and call the ED. was started, so Staff B continued until arrived and determine could be stopped. arrived 11:15 p.m. and authorized stopping . The ED said the resident was still in her day wear	A 025		

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A 025	Continued From page 3 and had not be changed to night wear when found. Record review of the Resident Hourly and . . . . Check-in sheet revealed Resident #1 was documented to be in her bedroom from 3:00 p.m. to 10:00 p.m. on . . . . . The section for Courtyard was blank from 3:00 p.m. to 10:00 p.m. This sheet was completed by resident aide Staff C. The sheet also documented that Resident #2, who was on a bedhold, was present in the bedroom from 3:00 p.m. to 10:00 p.m. Further that a blank space for #6 was also documented as in the bedroom from 3:00 p.m. to 10:00 p.m. Interview by telephone on . . . . . at 1:36 p.m., Resident Assistant ( ) Staff C said he had trained with another staff for several days when he first came to work. He had been on the Berry Ridge unit a few times, but did not know the residents as he was still learning their names and faces. He verified there was a book on the unit with pictures and information about each resident. He also verified there were pictures on the walls. He said that on he was putting people to bed between 7:00 to 8:00 p.m. He did not remember how many people were actually on Berry Ridge unit that night, but somewhere between 8 to 10 people. Then he started the laundry. He verified he left the unit after getting people to bed. He needed to borrow a phone charger, as he expected to have to take his mother to Tampa when he got off work. Staff C said he did not know the resident was missing until the relief staff came on duty and asked where Resident #1 was. He then checked that room and it was empty. He called the nurse who was on the other unit and began searching the unit. He verified the resident was found	A 025		

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A 025	Continued From page 4 outside in the gated courtyard unresponsive around 11:00 p.m. On at 12:05 p.m., observation of both units (Cloverdale & Berry Ridge) revealed the Medication Observation Record (MOR) book had photos of residents. Also a separate Resident Information book was kept on the desk by the computer in kitchen/dining area that holds all resident sheets with a photo of resident. Further resident charts contain a photo of resident inside front cover. A check of the Berry Ridge Resident Information book on at 11:53 am - showed a sheet & photo of Resident #1 still in book. Resident #1's chart contained a photo of the resident on inside front cover. Resident #1 was no longer in MOR book. Interview by telephone on at 10:52 a.m., agency CNA Staff A said she was working on Berry Ridge that day. She arrived at 4:00 p.m., after rounds. She said she was working with Staff C. She said she had not worked at this facility for 3 to 4 months and did not know the residents. She said during dining she asked the Dietary Aide delivering the meals, which residents were to get the specialized meals and the Dietary Aide pointed out those 3 residents to her, so she knew those 3 resident's names. Staff A said the nurse came in twice that night to pass medications. Staff A said at 7:00 p.m. she helped the 4 residents she knew get ready for bed and assisted Staff C to get others ready for bed as he requested. She said she did not do rounds on any resident as she did not know the residents. She verified Staff C was responsible for and did the hourly rounds. Interview by telephone on at 11:47 a.m.,	A 025		

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A 025	Continued From page 5 Agency LPN said she was working both units the night of . She verified she was on Berry Ridge unit multiple times to pass medications and check on the aides and make sure they were filling out the checks. She said she was on Cloverdale unit when Staff C called to say he thought he had put the wrong patient in the wrong bed and 1 resident was missing. She said Staff C seemed evasive. Agency LPN and agency CNA Staff B responded to the call and went to search the courtyard area. Agency CNA Staff B went 1 way and she went another. She hear Staff B call her and she rushed to where he was. The resident was down in the mulch next to the beach and palm tree. She checked for a , and thought there might be a faint , , but the resident was unresponsive and Staff B began . She called 911 and the administrator. She gave her keys to another staff to check the status. Resident #1 had a . She said continued as instructed by over the phone, until arrived on site, viewed the and was stopped. Agency nurse verified she had give Resident #1 medications around 8:00 p.m. that night and when found was in a short sleeved shirt and pants, not pajamas. A review of the investigation notes completed by the Administrative staff revealed, Staff C was seen by Agency LPN on the Cloverdale unit 3 times from 9:00 p.m. to 10:00 p.m. Interview on at 10:42 a.m., the ED said all the doors to the units are alarmed and will sound if someone attempts or goes out. The only door not alarmed is the kitchen door which leads directly to the courtyard area. She said witness statements revealed Staff C had left the unit 3 times that evening and had gone to the other unit. She said she reviewed the alarm reports and no	A 025		

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A 025	Continued From page 6 doors alarmed that night. She said the only way Resident #1 could have gotten out was through the kitchen door after seeing or following Staff C through the door. She said Staff C verified he had falsified the Resident Hourly and , Check-in sheet by just signing off and not actually observing the residents each hour; although he was able to tell her the correct hourly check procedure, including taking the book and observing the resident and documenting at that time. Interview on .. .... at 9:50 a.m., 9:57 a.m., 10:09 a.m. and 10:17 a.m. respectively, revealed Caregivers Staff E, F, G, and H knew Resident #1 and verified she walks all the time and prefers to be outside as much as possible. Caregiver Staff H said her favorite place to sit was the covered bench outside (near where the resident was found on at 11:00 p.m.). Class II	A 025		
A 163 SS=G	429.49 FS Records - Resident, Penalties for Alteration (1) Any person who fraudulently alters, defaces, or falsifies any medical or other record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. (2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination of license privileges. This Statute or Rule is not met as evidenced by: Based on record review, and interviews, the	A 163		

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A 163	Continued From page 7 facility failed to ensure staff assigned to do hourly checks completed the checks correctly rather than fill out the report without making the needed observations for 2 (Resdient #1 and #2) of 9 residents listed on the hourly check form. This failure lead to Resident #1 being outside from around 9:00 p.m. to 10:00 p.m. and when was not found timely. The findings included: Record review revealed Resident #1 was admitted to the facility on with diagnosis including (rapid rate with poor flow), essential (high ,), , and (rapid heartbeat out of proportion to activity). No caregiver or nurse notes were present in Resident #1's record after . A ( ) form was completed on . Record review of the Resident Hourly and Check-in sheet revealed Resident #1 was documented to be in her bedroom from 3:00 p.m. to 10:00 p.m. on . The section for Courtyard was blank from 3:00 p.m. to 10:00 p.m. This sheet was completed by resident aide Staff C. The sheet also documented that Resident #2, who was on a bedhold, was present in the bedroom from 3:00 p.m. to 10:00 p.m. Further that a blank space for #6 was also documented as in the bedroom from 3:00 p.m. to 10:00 p.m. Interview by telephone on at 10:52 a.m., agency CNA Staff A said she was working on Berry Ridge that day. She arrived at 4:00 p.m., after rounds. She said she was working with Staff C. She said she had not worked at this	A 163		

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A 163	Continued From page 8 facility for 3 to 4 months and did not know the residents. She said during dining she asked the Dietary Aide delivering the meals, which residents were to get the specialized meals and the Dietary Aide pointed out those 3 residents to her, so she knew those 3 resident's names. Staff A said the nurse came in twice that night to pass medications. Staff A said at 7:00 p.m. she helped the 4 residents she knew get ready for bed and assisted Staff C to get others ready for bed as he requested. She said she did not do rounds on any resident as she did not know the residents. She verified Staff C was responsible for and did the hourly rounds. Interview on at 10:42 a.m., the ED said Staff C verified he had falsified the Resident Hourly and , Check-in sheet by just signing off and not actually observing the residents each hour; although he was able to tell her the correct hourly check procedure, including taking the book and observing the resident and documenting at that time. Class II	A 163		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and	A 165		

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A 165	Continued From page 9 develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency ' s online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency ' s online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in	A 165		

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A 165	Continued From page 10	A 165		

this section. The report must include the results of the facility ' s investigation into the adverse incident.

(6) . . . . , neglect, or . . , ... must be reported to the Department of Children and Families as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.
(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.
(10) The agency may adopt rules necessary to

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administer this section.

59A-36.016 Adverse Incident Report.
(1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting.
(2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting.

This Statute or Rule is not met as evidenced by:
Based on record review, and interviews, the facility failed to fill a day 1 adverse incident for a condition requiring medical attention including failure to honor advanced directives for 1 (Resident #1) of 1 resident reviewed.

The findings included;

Record review revealed Resident #1 was admitted to the facility on with diagnosis including (rapid rate with poor flow), essential (high), , and (rapid heartbeat out of proportion to activity).
No caregiver or nurse notes were present in Resident #1's record after .
A ( ) form was completed on .
A review of the Resident Health Assessment Form 1823 dated noted the resident was independent with walking, , eating, self care (grooming), toileting and transfer, and only

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A 165	Continued From page 12 needed assistance with bathing. An undated Resident Health Assessment Form 1823 dated revealed Resident #1 was still independent in ambulation, toileting and transfer. Interview by telephone on at 11:47 a.m., Agency LPN said she was working both units the night of . She said she was on Cloverdale unit when Staff C called to say he thought he had put the wrong patient in the wrong bed and 1 resident was missing. She said Staff C seemed evasive. Agency LPN and agency CNA Staff B responded to the call and went to search the courtyard area. Agency CNA Staff B went 1 way and she went another. She hear Staff B call her and she rushed to where he was. The resident was down in the mulch next to the beach and palm tree. She checked for a , and thought there might be a faint , but the resident was unresponsive and Staff B began . She called 911 and the administrator. She gave her keys to another staff to check the status. Resident #1 had a . She said continued as instructed by over the phone, until arrived on site, viewed the and was stopped. Interview on at 8:57 a.m., the Executive Director (ED) said she was here on when the missing resident incident occurred. She had received a call at 11:05 p.m. from agency LPN at the change of shift. The ED said the caregivers did rounds and found Resident #1 not in her room. Agency CNA Staff B and agency LPN searched the courtyard, while the other caregivers searched house. Agency Staff B found Resident #1 down with her arms underneath her, called out to agency LPN and rolled her over to assess. Agency LPN called 911. Agency CNA Staff B stayed with the resident doing	A 165		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 165	Continued From page 13 ( ) while agency LPN went to find the ( ) status and call the ED. was started, so Staff B continued until arrived and determine could be stopped. arrived 11:15 p.m. and authorized stopping When asked about filling an adverse incident report, ED said she had not completed her investigation yet; she had discussed it with corporate and they did not feel it rose to and adverse incident as the resident was never off the premises and did not die from , but rather had a natural . When asked about completing for someone who had a , she verified that would be an adverse incident. The Ed agreed the adverse incident report should have been filled immediately. Class III	A 165		

Agency for Health Care Administration

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	AL11964952	A. BUILDING: ______ B. WING ______	08/13/2021

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A 000	Initial Comments An unannounced complaint survey #2021011172 was conducted on ... at Arden Courts of Sarasota, an assisted living facility in Sarasota, Florida. Complaint # 2021011172 had 2 allegations both of which were substantiated. The following is a description of the deficiencies: .	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [illegible] or [illegible] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [illegible] or [illegible]. 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 must notify the resident ' s representative or designee of the need for health care services and must assist in making [illegible] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents	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 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 59A-36.012, F.A.C. (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. (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 interviews, and record reviews, the facility failed to provide adequate supervision and documentation to ensure the safety and needs were met and failed to document in the resident record for 1 (Resident #1) of 8 residents on Berryridge unit The findings included:	A 025		

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A 025	Continued From page 2 Record review revealed Resident #1 was admitted to the facility on with diagnosis including (rapid rate with poor flow), essential (high), , and (rapid heartbeat out of proportion to activity). No caregiver or nurse notes were present in Resident #1's record after . A ( ) form was completed on . A review of the Resident Health Assessment Form 1823 dated noted the resident was independent with walking, , eating, self care (grooming), toileting and transfer, and only needed assistance with bathing. An undated Resident Health Assessment Form 1823 dated revealed Resident 31 was still independent in ambulation, toileting and transfer. Interview on at 8:57 a.m., the Executive Director (ED) said she was at the facility on when the missing resident incident occurred. She had received a call at 11:05 p.m. from agency LPN at the change of shift. The ED said the caregivers did rounds and found Resident #1 not in her room. Agency CNA Staff B and agency LPN searched the courtyard, while the other caregivers searched house. Agency Staff B found Resident #1 down with her arms underneath her, called out to agency LPN and rolled her over to assess. Agency LPN called 911. Agency CNA Staff B stayed with the resident doing , , ( ) while agency LPN went to find the ( ) status and call the ED. was started, so Staff B continued until arrived and determine could be stopped. arrived 11:15 p.m. and authorized stopping . The ED said the resident was still in her day wear	A 025		

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A 025	Continued From page 3	A 025		

and had not be changed to night wear when found.

Record review of the Resident Hourly and , Check-in sheet revealed Resident #1 was documented to be in her bedroom from 3:00 p.m. to 10:00 p.m. on . The section for Courtyard was blank from 3:00 p.m. to 10:00 p.m. This sheet was completed by resident aide Staff C.
The sheet also documented that Resident #2, who was on a bedhold, was present in the bedroom from 3:00 p.m. to 10:00 p.m. Further that a blank space for #6 was also documented as in the bedroom from 3:00 p.m. to 10:00 p.m.

Interview by telephone on at 1:36 p.m., Resident Assistant ( ) Staff C said he had trained with another staff for several days when he first came to work. He had been on the Berry Ridge unit a few times, but did not know the residents as he was still learning their names and faces. He verified there was a book on the unit with pictures and information about each resident. He also verified there were pictures on the walls. He said that on he was putting people to bed between 7:00 to 8:00 p.m. He did not remember how many people were actually on Berry Ridge unit that night, but somewhere between 8 to 10 people. Then he started the laundry. He verified he left the unit after getting people to bed. He needed to borrow a phone charger, as he expected to have to take his mother to Tampa when he got off work.
Staff C said he did not know the resident was missing until the relief staff came on duty and asked where Resident #1 was. He then checked that room and it was empty. He called the nurse who was on the other unit and began searching the unit. He verified the resident was found

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A 025	Continued From page 4 outside in the gated courtyard unresponsive around 11:00 p.m. On at 12:05 p.m., observation of both units (Cloverdale & Berry Ridge) revealed the Medication Observation Record (MOR) book had photos of residents. Also a separate Resident Information book was kept on the desk by the computer in kitchen/dining area that holds all resident sheets with a photo of resident. Further resident charts contain a photo of resident inside front cover. A check of the Berry Ridge Resident Information book on at 11:53 am - showed a sheet & photo of Resident #1 still in book. Resident #1's chart contained a photo of the resident on inside front cover. Resident #1 was no longer in MOR book. Interview by telephone on at 10:52 a.m., agency CNA Staff A said she was working on Berry Ridge that day. She arrived at 4:00 p.m., after rounds. She said she was working with Staff C. She said she had not worked at this facility for 3 to 4 months and did not know the residents. She said during dining she asked the Dietary Aide delivering the meals, which residents were to get the specialized meals and the Dietary Aide pointed out those 3 residents to her, so she knew those 3 resident's names. Staff A said the nurse came in twice that night to pass medications. Staff A said at 7:00 p.m. she helped the 4 residents she knew get ready for bed and assisted Staff C to get others ready for bed as he requested. She said she did not do rounds on any resident as she did not know the residents. She verified Staff C was responsible for and did the hourly rounds. Interview by telephone on at 11:47 a.m.,	A 025		

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A 025	Continued From page 5 Agency LPN said she was working both units the night of . She verified she was on Berry Ridge unit multiple times to pass medications and check on the aides and make sure they were filling out the checks. She said she was on Cloverdale unit when Staff C called to say he thought he had put the wrong patient in the wrong bed and 1 resident was missing. She said Staff C seemed evasive. Agency LPN and agency CNA Staff B responded to the call and went to search the courtyard area. Agency CNA Staff B went 1 way and she went another. She hear Staff B call her and she rushed to where he was. The resident was down in the mulch next to the beach and palm tree. She checked for a , and thought there might be a faint , , but the resident was unresponsive and Staff B began . She called 911 and the administrator. She gave her keys to another staff to check the status. Resident #1 had a . She said continued as instructed by over the phone, until arrived on site, viewed the and was stopped. Agency nurse verified she had give Resident #1 medications around 8:00 p.m. that night and when found was in a short sleeved shirt and pants, not pajamas. A review of the investigation notes completed by the Administrative staff revealed, Staff C was seen by Agency LPN on the Cloverdale unit 3 times from 9:00 p.m. to 10:00 p.m. Interview on at 10:42 a.m., the ED said all the doors to the units are alarmed and will sound if someone attempts or goes out. The only door not alarmed is the kitchen door which leads directly to the courtyard area. She said witness statements revealed Staff C had left the unit 3 times that evening and had gone to the other unit. She said she reviewed the alarm reports and no	A 025		

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A 025	Continued From page 6 doors alarmed that night. She said the only way Resident #1 could have gotten out was through the kitchen door after seeing or following Staff C through the door. She said Staff C verified he had falsified the Resident Hourly and , Check-in sheet by just signing off and not actually observing the residents each hour; although he was able to tell her the correct hourly check procedure, including taking the book and observing the resident and documenting at that time. Interview on ... . at 9:50 a.m., 9:57 a.m., 10:09 a.m. and 10:17 a.m. respectively, revealed Caregivers Staff E, F, G, and H knew Resident #1 and verified she walks all the time and prefers to be outside as much as possible. Caregiver Staff H said her favorite place to sit was the covered bench outside (near where the resident was found on at 11:00 p.m.). Class II	A 025		
A 163	429.49 FS Records - Resident, Penalties for Alteration (1) Any person who fraudulently alters, defaces, or falsifies any medical or other record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. (2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination of license privileges. This Statute or Rule is not met as evidenced by: Based on record review, and interviews, the	A 163		

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A 163	Continued From page 7 facility failed to ensure staff assigned to do hourly checks completed the checks correctly rather than fill out the report without making the needed observations for 2 (Resdient #1 and #2) of 9 residents listed on the hourly check form. This failure lead to Resident #1 being outside from around 9:00 p.m. to 10:00 p.m. and when . . . was not found timely. The findings included: Record review revealed Resident #1 was admitted to the facility on . . . with diagnosis including (rapid rate with poor . . . . flow), essential (high , . .), , and , (rapid heartbeat out of proportion to activity). No caregiver or nurse notes were present in Resident #1's record after . . . . . A ( ) form was completed on . . . . Record review of the Resident Hourly and , Check-in sheet revealed Resident #1 was documented to be in her bedroom from 3:00 p.m. to 10:00 p.m. on . The section for Courtyard was blank from 3:00 p.m. to 10:00 p.m. This sheet was completed by resident aide Staff C. The sheet also documented that Resident #2, who was on a bedhold, was present in the bedroom from 3:00 p.m. to 10:00 p.m. Further that a blank space for #6 was also documented as in the bedroom from 3:00 p.m. to 10:00 p.m. Interview by telephone on at 10:52 a.m., agency CNA Staff A said she was working on Berry Ridge that day. She arrived at 4:00 p.m., after rounds. She said she was working with Staff C. She said she had not worked at this	A 163		

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A 163	Continued From page 8 facility for 3 to 4 months and did not know the residents. She said during dining she asked the Dietary Aide delivering the meals, which residents were to get the specialized meals and the Dietary Aide pointed out those 3 residents to her, so she knew those 3 resident's names. Staff A said the nurse came in twice that night to pass medications. Staff A said at 7:00 p.m. she helped the 4 residents she knew get ready for bed and assisted Staff C to get others ready for bed as he requested. She said she did not do rounds on any resident as she did not know the residents. She verified Staff C was responsible for and did the hourly rounds. Interview on at 10:42 a.m., the ED said Staff C verified he had falsified the Resident Hourly and , Check-in sheet by just signing off and not actually observing the residents each hour; although he was able to tell her the correct hourly check procedure, including taking the book and observing the resident and documenting at that time. Class II	A 163		
A 165	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and	A 165		

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A 165	Continued From page 9 develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency ' s online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency ' s online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in	A 165		

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A 165	Continued From page 10 this section. The report must include the results of the facility ' s investigation into the adverse incident. (6) . . . . ., neglect, or . . , ... must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to	A 165		

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A 165	Continued From page 11	A 165		

administer this section.

59A-36.016 Adverse Incident Report.
(1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting.
(2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting.

This Statute or Rule is not met as evidenced by:
Based on record review, and interviews, the facility failed to fill a day 1 adverse incident for a condition requiring medical attention including failure to honor advanced directives for 1 (Resident #1) of 1 resident reviewed.

The findings included;

Record review revealed Resident #1 was admitted to the facility on with diagnosis including (rapid rate with poor flow), essential , (high ,), , and (rapid heartbeat out of proportion to activity).
No caregiver or nurse notes were present in Resident #1's record after .
A ( ) form was completed on .
A review of the Resident Health Assessment Form 1823 dated noted the resident was independent with walking, , eating, self care (grooming), toileting and transfer, and only

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A 165	Continued From page 12 needed assistance with bathing. An undated Resident Health Assessment Form 1823 dated . . .. revealed Resident #1 was still independent in ambulation, toileting and transfer. Interview by telephone on at 11:47 a.m., Agency LPN said she was working both units the night of . . She said she was on Cloverdale unit when . Staff C called to say he thought he had put the wrong patient in the wrong bed and 1 resident was missing. She said Staff C seemed evasive. Agency LPN and agency CNA Staff B responded to the call and went to search the courtyard area. Agency CNA Staff B went 1 way and she went another. She hear Staff B call her and she rushed to where he was. The resident was ..... down in the mulch next to the beach and palm tree. She checked for a , and thought there might be a faint ,. . . ., but the resident was unresponsive and Staff B began . .. She called 911 and the administrator. She gave her keys to another staff to check the . status. Resident #1 had a . . . She said . continued as instructed by over the phone, until . arrived on site, viewed the and was stopped. Interview on at 8:57 a.m., the Executive Director (ED) said she was here on .. .. when the missing resident incident occurred. She had received a call at 11:05 p.m. from agency LPN at the change of shift. The ED said the caregivers did rounds and found Resident #1 not in her room. Agency CNA Staff B and agency LPN searched the courtyard, while the other caregivers searched house. Agency Staff B found Resident #1 . . . down with her arms underneath her, called out to agency LPN and rolled her over to assess. Agency LPN called 911. Agency CNA Staff B stayed with the resident doing	A 165		

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
	AL11964952	A. BUILDING: ______ B. WING ______	08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF SARASOTA	5509 SWIFT ROAD SARASOTA, FL 34231

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A 165	Continued From page 13 ( ) while agency LPN went to find the ( ) status and call the ED. was started, so Staff B continued until arrived and determine could be stopped. arrived 11:15 p.m. and authorized stopping When asked about filling an adverse incident report, ED said she had not completed her investigation yet; she had discussed it with corporate and they did not feel it rose to and adverse incident as the resident was never off the premises and did not die from , but rather had a natural . When asked about completing for someone who had a , she verified that would be an adverse incident. The Ed agreed the adverse incident report should have been filled immediately. Class III	A 165		