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
	AL11969489	A. BUILDING: _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT NAPLES PRESERVE	3490 DR NAPLES, FL 34109

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A 000	Initial Comments An unannounced complaint survey for complaint #2020011375 & #2020002339 and emergency power plan monitoring was conducted through [redacted] at Keystone Place at Naples Preserve, an assisted living facility in Naples, Florida. Complaint #2020002339 was substantiated at A0025 & A0030. Complaint #2020011375 was substantiated at A0025 & A0030. The following is 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 must notify a licensed physician when a resident exhibits signs of [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:	A 025		

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A 025	Continued From page 1 (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 observation, record review and staff interviews, the facility failed to ensure a safe environment and adequate supervision to meet the resident's needs for 2 (Resident #3 and #5) of 3 residents reviewed in the memory care unit for . . . The facility failed to provide adequate supervision that led to Resident # 3 falling 6 times in 22 days and being transferred to the hospital for evaluation. The facility failed to provide adequate supervision that led to Resident #5 falling 7 times in 12 days and having to be transferred to the hospital for evaluation.	A 025		

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A 025	Continued From page 2 The findings included: 1. Review of resident records noted Resident #2 was a male admitted to the memory care unit of the facility on with the following diagnosis: 's, and ( ) and a history of falling. On review of the documentation it was noted the resident had 16 times in 33 days and had complaint of , often. On in review of Advanced Registered Nurse Practitioner's (ARNP) initial assessment she wrote, "Resident has extensive history of 's with increasing and . The resident will begin , secondary to sarcopenia and for and unsteady gait and ." She also said in her plan that Resident #2 needed skilled nursing for process management & medication management. The ARNP also recorded his wife stated Resident #2 took a before moving to the facility and "had a full work up", saying Resident #2 will complain of intermittent , and there was still present. On review of Resident #2's medical record the following and complaint of , were noted: On moved in with to right side of and due to at home. On complained of , to , . 800 milligram (mg) ordered every 8 hours as needed. ARNP notified. On resident alert and complained of , in , . ARNP visited gave new order for and labs UA/C&S. On - found lying on bedroom floor beside his bed. On - found on bedroom floor.	A 025		

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A 025	Continued From page 3 On . . . . . - found on bedroom floor by private duty at 7 p.m. Resident complaining of right . . , . . On - x2 this shift resident observed leaning to Right side while ambulating. Leaning intensified post first . Resident's , ... ( ) decreased from . . . to . . . . On - found on bedroom floor beside his bed. No documentation that wife was called or the ARNP being notified. On . . . . . - physical . . . , . . recommends use of wheel chair for resident. Resident #2 received pendant (call system) and education. (resident has noted and forgetfulness) 2 were recorded on incident report log on this date, but no mentioned in the observation notes On . . . . . - found lying on bedroom floor Resident #2 complaining of , twice. On . . . . . - Resident #2 asked if he was having , and he said his hurt. On . . . . . at 3:15 p.m. . - Resident #2 complaining about right , and received , med earlier in the day. There was no documentation of the wife or the ARNP being notified. On - , said Resident #2 needed private duty and was a high risk. Resident #2 had a today recorded on incident report listing but was not mentioned in observation notes. On at 7:30 a.m., Resident #2 was reported as a on incident report listing but no mention of the in observation notes. On . . . . . at 7 p.m., Resident complaining of , , (unknown were , is). On . . . . . at 9:30 a.m. . - found naked on bathroom floor. No documentation of wife or ARNP being notified. On physical , working with Resident #2 said he is "A Huge risk. He is not safe here.". The , said Resident #2 is a	A 025		

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A 025	Continued From page 4 lot weaker and his are especially weak. Told staff to put certified nursing assistant (CNA) to do 1:1 the rest of the day. No documentation the ARNP and wife were notified. On at 11:30 a.m., Resident #2 was observed leaning on right side in wheelchair for majority of morning. Resident #2 was assisted to bathroom twice then 20 minutes later again. Resident #2 grabbed the assist bar and proceeded to lean and put all on right side and lost balance. Resident #2 was unable to urinate. On at 6:15 p.m., nurse got a verbal order from the ARNP to order 100 mg (a medication) at bedtime. On at 10:03 a.m., a was indicated in incident report listing but not mentioned in observation notes. On at 5:47 p.m., a was indicated in incident report listing but not mentioned in observation notes. On Resident #2 complained of generalized and requested medication. On - Resident #2 was found sitting on bedroom floor. 2. On review of Resident #3's medical record, it was noted the resident was admitted to the facility on and has 6 times in 22 days. Resident Health Assessment dated admitting diagnosis: ataxia, muscular deconditioning. S/P valve replacement (TAVR), idiopathic , and risk. Doctors' orders: oxegen (02) checks 3 times a day if lower than 92% place 02 at 2 litters canula. Must wear 02 at night. On at 6:45 p.m., Resident #3 was alert	A 025		

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A 025	Continued From page 5 but forgetful. Limited range of motion. Left lower extremity straight forward and unable to bend due to a prior long-term injury. Resident was able to walk very minimally with . On at 9:00 p.m., Resident #3 was found on the floor in her bedroom, stated she slipped out of her wheelchair. Husband, wellness director and ARNP were notified. On at 3 p.m., observation notes said Resident #3 had 2 today and was sent to the emergency room (ER) via emergency management service ( ) after second . ER note -Hematoma in the of the bead. Acute hematoma was noted on the scan from the emergency department, which was identified as happening in a in , her husband said. On at 4:15 p.m., the physician regional nurse called at 12:00 p.m. leaving a report. The nurse stated Resident #3 had no new changes of subdermal hematoma and open . Resident #3 received due to upon exertion. She complained of right , , except , abnormal level. Returned to the facility. In the hospital for 3 days. On after return to the facility at 4:52 p.m., the resident had another in her room. On at 6:52 p.m. - recorded on incident report log but not noted in the observation record. Unknown what happened. On at 6:50 p.m. - recorded on incident report log but not noted in the observation record. 3. On in review of Resident #5's medical	A 025		

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A 025	Continued From page 6 record, it showed that the resident had 7 in 12 days. Resident #5 was admitted to the facility on . Resident Health Assessment signed on was admitted with the following diagnosis: , luminary tract ( ), overactive . (not on helth assessment but in history, 's) On at 9:00 p.m. (happened at 10:06 a.m. according to incident report log) Resident #5 was found sitting on the bedroom floor beside her bed. The resident sustained to her left , left and . On at 8:15 p.m. Resident #5 was found on her beside her bed (carting done a long time after event). No incident report recorded even though it was not a witnessed event. - complaining of general , - Resident #5 was found lying in prone position on bedroom floor. Resident #5 was assessed to standing and reports being , and thirsty. - Resident #5 was found lying on floor in front of her wheelchair on her in common area. Two noted to her forehead. called and Resident #5 was transported to the ER for evaluation. 6:50 a.m., recorded on incident report but no charting in observation note. Unknown if her husband, ARNP or wellness director were notified, nknown injury. aide reported Resident #5 had on	A 025		

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A 025	Continued From page 7 her . Resident #5 was observed in the common area with a group of residents playing activities with 2 large scratches on right side of her middle . - Resident #5 was observed leaning to her right side and had to be assisted with meals. . - caregiver reports Resident #5 was restless, sitting in her wheelchair in the activity area, slipped out of her wheelchair and on the floor. - no not of a , but note that resident returned for PRMC, CT , reveal no . CT reveal not acute abnormality, , with , reveal no . Her husband, ARNP and the wellness director were notified. . - observation note put in after the previous one. Records Resident #5 sitting in a wheelchair (W/C) in the common area and was observed standing on her own, losing her balance, and falling forward striking the left side of her causing a . Resident #5 did not lose . was called and transported her to the ER for evaluation. 4. On at 2:50 p.m., in an interview with Certified Nursing Assistant (CNA) Staff A, she said it is hard to watch all the residents mostly the ones who have a lot of . 5. On at 3:30 p.m., in an interview with Staff E, she said there are multiple residents who have had many and she thinks that there is not enough staff on the unit to monitor all the memory care resident and the ones who are at high risk for .	A 025		

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A 025	Continued From page 8 6. On at 5:12 p.m., in an interview with the Director of Health and Wellness, she said she felt there was enough staff in the memory care unit and the residents who a lot were just getting acclimated to their new surroundings. She said she did not put the residents who were frequently falling on any extra watch by staff. Class III	A 025		
A 030	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline	A 030		

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A 030	Continued From page 9 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . . , neglect, and . ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which	A 030		

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A 030	Continued From page 10 residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other	A 030		

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A 030	Continued From page 11 similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is	A 030		

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A 030	Continued From page 12 harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally [illegible], the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without [illegible], 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. (2) The administrator of a facility shall ensure that a written notice of the rights, [illegible], and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and, if applicable, [illegible], Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are	A 030		

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A 030	Continued From page 13 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. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (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 representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide a safe, clean and comfortable environment in the memory care unit as recommended by the Centers for Control and Prevention (CDC) guidelines in the COVID pandemic. The facility failed to provide a safe living environment. The facility did not have	A 030		

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	AL11969489	A. BUILDING: _____ B. WING _____	07/16/2020

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A 030	Continued From page 14 safe practices for social/physical distancing or wearing of masks in the COVID environment. The facility did not recognize the environmental hazards of the functioning drinking fountains. Hazardous cleaning products were being left in areas that memory care residents could get into them or that medical treatment that enhances the COVID ability to travel in the air and to cause harm. The findings included: "COVID-19 spreads mainly among people who are in close contact (within about 6) for a prolonged period. Spread happens when an person coughs, sneezes, or talks, and droplets from their or are launched into the air and land in the mouths or noses of people nearby. The droplets can also be inhaled into the . Recent studies indicate that people who are but do not have symptoms likely also play a role in the spread of COVID-19. Since people can spread the before they know they are sick, it is important to stay at least 6 away from others when possible, even if you-or they-do not have any symptoms. Social distancing is especially important for people who are at higher risk for severe illness from COVID-19." From: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html On at 12:07 p.m., as the surveyor entered the memory care unit, and upon entering the main living area, 28 memory care residents were observed sitting it a full dining room with multiple tables of 3, 4, and 6 people. None of the residents had a mask on because they were eating lunch. Some private care givers were also	A 030		

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A 030	Continued From page 15 noted sitting beside the tables. The tables appeared to be apart. No social distancing was observed in the dining room area. Upon observation of the open concept area, there were many other tables not being used adjacent to the dinning area and there was another dining area with multiple tables with chairs on the other side. On at 12:10 p.m., in an interview with the Administrator about the residents sitting so close together, he said they had been working on the area on the other side, so they were not using that area at the present time. The Administrator also said that at the table with 6 residents, there were 2 husbands from the assisted living facility (ALF) that had come to eat with their wives and a resident from the independent living apartment that comes to each meal to eat with his wife. The Administrator also said the husband that lives in the independent side is not screened for temperature or symptoms upon coming into the memory care unit and is able to come and go from the facility at will. He also said that he was aware of the need for social distancing of the resident, and in the ALF portion of the facility the do not currently have any communal dining. On at 12:12 p.m., in an interview with the Director of Health & Wellness, she said the independent resident is not screened upon coming into the memory care unit to have meals with his wife each day. "Some procedures performed on patients are more likely to generate higher concentrations of , aerosols than coughing, sneezing, talking, or breathing. These aerosol generating procedures (AGPs) potentially put healthcare personnel and others at an increased	A 030		

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A 030	Continued From page 16 risk for , exposure and ... Based on limited available data, it is uncertain whether aerosols generated from some procedures may be , such as: administration* ohigh flow delivery *Aerosols generated by are derived from medication in the . It is uncertain whether potential associations between performing this common procedure and increased risk of might be due to aerosols generated by the procedure or due to increased contact between those administering the nebulized medication and patients." On at 12:07 p.m., Resident #1 was observed in her room sitting in her wheelchair, approximately 10 from the door receiving an aerosol updraft treatment via mask. The machine was running, a private care giver was sitting beside her and the door to the hallway was open. No nurse was seen in the room. The resident and the caregiver waved at the surveyor. On at 12:08 p.m. In an interview with the Administrator and the Wellness Director, at the time of the observation they both said they were unaware of any precautions for a resident doing aerosol updraft treatment during the COVID pandemic. CDC recommends that people wear cloth coverings in public settings and when around people who don't live in your household, especially when other social distancing measures are difficult to maintain. Cloth coverings may help prevent people who have COVID-19 from spreading the to others. Cloth coverings are most likely to reduce the	A 030		

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A 030	Continued From page 17 spread of COVID-19 when they are widely used by people in public settings. https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth- -cover-guidance.html On at 2:50 p.m., a second tour of the memory care unit showed multiple residents sitting in the living room area on long couches. There were also residents sitting beside each other watching the television (TV) on the wall. No residents seen in the memory care unit had any masks on. On at 3:55 p.m., in an interview with Licensed Practical Nurse (LPN) Staff B, she said the facility had not tried to have the memory care residents wear masks because they do not understand about this pandemic. She said the residents would not keep them on. On at 2:44 p.m., while touring the memory care unit, cleaning chemicals such as bathroom tile cleaner, pop up wipes and another spray bottle cleaners were observed on an unattended cleaning cart in the hall of the memory care unit. There were also 2 different areas that had cleaning spray bottles on the counter within easy reach of residents. (picture attached) On at 2:56 p.m. in an interview with Staff F in the memory care unit, she said the cleaning cart that the surveyor saw was her cleaning cart, and she acknowledged that it was not right to leave it unattended with chemicals that a memory care resident could get into. On at 3:10 p.m., in an interview with the program director of the memory care unit, she said she has seen the spray bottle with cleaning	A 030		

Agency for Health Care Administration

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A 030	Continued From page 18 solution left in the common area by the sink many times and she thought it was a danger to residents. Class III	A 030		