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
	AL11967402	A. BUILDING: _____ B. WING _____	06/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCELSIOR OMEGA INC	15 DADE AVE SARASOTA, FL 34232

(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 An Control Focused Visit and Complaint survey for complaint #2020000187 was conducted on through at Excelsior Omega Inc., an assisted living facility in Sarasota, Florida. The Control Focused and Complaint #2020000187 survey was completed in conjunction with Control Focused and Generator Variance revisit. Complaint #2020000187 was substantiated at tag A0025, A0165 and A0010. The following is description of the deficiencies.	A 000		
A 010	429.26(&9) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (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	A 010		

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A 010	Continued From page 1 the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (2) A physician, physician assistant, or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility. (9) A , ill resident who no longer meets the criteria for continued residency may remain in 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. 59A-36.006 (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 -to- 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 59A-36.002, 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: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a pressure	A 010		

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A 010	Continued From page 2 . . . may be retained provided that: 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, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (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: 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; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 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, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (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.	A 010		

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A 010	Continued From page 3 (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. (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents have a -to-medical examination by a health care provider at least every 3 years for 1 (Resident #2) of 3 resident records reviewed. The findings included: Record review of Resident #2's chart on . . . . . , revealed a Resident Health Assessment Form 1823 (1823) that was dated . . . . No updated 1823 was found in his chart. On at 1:34 p.m., the Administrator thought she had taken him for a new examination recently. The Administrator contacted the doctors office who informed her the last 1823 examination they did was . The Administrator said she would get him an examination. Class III	A 010		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26	A 025		

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A 025	Continued From page 4 (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. 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) 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	A 025		

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A 025	Continued From page 5 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 record review and interview, the facility failed to offer personal supervision appropriate to each resident's needs; failed to make daily observation of the residents general health, safety, and physical well-being; failed to contact the residents health care provider and/or family with a change in condition and failed to maintain a written record of changes that resulted in need for medical attention for 1 (Resident #1) of 3 resident records reviewed. Failure to contact a health care provider, or family when a change in condition occurs allows a condition to go undiagnosed or treated. Failure to document progress notes prevents communication between staff and any health care provider reviewing the record. The findings included: On at 11:43 a.m., in a telephone call with Resident #1's mother, she said she picked up her son for the 2019 Thanksgiving holiday and when she removed his shirt for a bath, she discovered "over 50 marks" on him. She said her son has [redacted] and is unable to talk and could not tell her what happened. Resident #1's mother said she took photos and sent them via text message to the facility Administrator. Resident #1's mother said the Administrator responded and said it was [redacted] and they had been putting lotion on it. Resident #1's mother said the facility never reported it to her or got him	A 025		

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A 025	Continued From page 6 any medical assistance. Resident #1's mother said she contacted the police who documented all the marks, took photos and the police called the hotline. Resident #1's mother said she took her son to the hospital who confirmed the marks were bite marks and the hospital staff notified the hotline. Record review of Resident #1's chart on revealed no documentation of Resident #1 having any skin issues. Resident #1's chart contained no progress notes at all. There was no documentation found of a doctor being notified or that his mother had been contacted. There was no documentation that the police or Adult Protective Services had been to the facility to investigate the issue. On at 11:26 a.m., in an interview, the Administrator said Resident #1 was able to walk around, he was not in a wheelchair. He was showered in the evening and when he got up, he had red marks on his and all over his body. The Administrator said It looked like . At first, she said: We thought it was bed bugs. We checked the whole room, there was nothing. It looked like , after the first shower it started to clear up. We called the doctor, and it was Thanksgiving week so we couldn't see doctor until Monday. I called his mother after we saw the irritation on his , she didn't answer. She picked him up to take for Thanksgiving and called and said he looked like he had a bunch of pinch marks. On at 1:17 p.m., in an interview, the Administrator said an Adult Protective Investigator (API) came to the facility saying someone bit Resident #1 in the . The Administrator said it was not possible, he is not in the wheelchair, he	A 025		

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A 025	Continued From page 7 is mobile and can walk around. It was a small house and she didn't see anyone bite him. The Administrator said no one saw anyone bite him. The Administrator said they have never had an incident like that before and never had anything like that after. The Administrator said it just looked like irritation all over his body, all over his . The Administrator said we don't keep progress notes in the charts, but as far as she could see, it looked nothing looked like a bite. The Administrator said they showered him, and they would see a bite. The Administrator said she cannot recall who would have showered him as it was a long time ago. The Administrator said when the lady API came , she said she was closing the case because the only thing she can think of is somebody bit him in the . On at 1:34 p.m., in an interview, the Administrator said there was no documentation of notifying family or documenting call to the doctor or the condition of Resident #1's skin. The Administrator said she investigated and tried to talk to the residents. The Administrator said she concluded he went to bed and woke up with it, and he was itching also. We thought it was . On the facility sent written paperwork which was not in Resident #1's record. The paperwork included an Activities of Daily Living (ADL) flow sheet noting showers were given daily from through , but none for . The flow sheet had apparent initials of the staff person daily only for and part of . The paperwork also included Resident #1's progress notes from to which appeared to all be written in the same , with dates, but not times or signatures. The note	A 025		

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A 025	Continued From page 8 documented staff noticed that date that Resident #1's " is very irritated," that Resident #1's family member was "called," and "the Doctor he is scheduled to see Doctor." On at 8:20 a.m., in an interview, the Adult Protective Investigator (API) said Resident #1 had been picked up by his mother for the Thanksgiving 2019 holiday. His mother discovered the marks, contacted the police and took him to the emergency room. API said she personally saw the marks and said they were definitely bite marks. API felt there was no way someone giving him a bath or shower would not have seen them. API said the marks were at all stages and colors and you could count the where it was . . . . API said she had taken photos and showed them to the facility Administrator who said it was a skin irritation. The API said she was never able to talk to the person who gave Resident #1 his showers as there was no documentation and per the Administrator, staff had changed. The API said she also had the hospital report which described it as an assault on a non-verbal patient. Class II	A 025		
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	A 165		

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A 165	Continued From page 9 reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and 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, by electronic mail, facsimile, or United States 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, by electronic mail, facsimile, or United States mail, a full report to the agency on all	A 165		

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A 165	Continued From page 10 adverse incidents specified in 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 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 interview, the facility failed to submit a preliminary report within 1 business day after the occurrence of an adverse incident and further failed to provide a full report to the Agency for Healthcare Administration (AHCA) within 15 days to include the facility's investigation into the adverse incident. The findings included: On . . . . . at 11:26 a.m., in an interview, the Administrator admitted she was aware Resident #1's mother said she had found multiple marks on his body after bringing him home for the 2019 Thanksgiving holiday. The Administrator admitted she was aware Resident #1's mother had taken him to the hospital to be examined due to the marks on his body. The Administrator admitted Adult Protective Services had come to her facility to do an investigation regarding Resident #1. The Administrator said she filed an incident report with AHCA and provided a copy of	A 165		

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A 165	Continued From page 12 the Assisted Living facility Initial Adverse Incident Report 1 Day form. On at 1:17 p.m., in an interview, the Administrator said when Adult Protective Services came , they informed her they were closing the case and the Adult Protective Investigator said they felt it had been bite marks. The Administrator said the police never came to the facility but she had been told they had been called so she put the information on an incident report. On . . . . . at 8:30 a.m., a review of the AHCA incident reporting system showed a 1 day or 15 day report had never been filed. Class II	A 165		