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
	AL11910533	A. BUILDING: _____ B. WING _____	02/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PHILLIPPI CREEK	5501 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)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint survey for #2020005319 and #2020017328 was conducted from through at Brookdale Phillippi Creek, an assisted living facility in Sarasota, Florida. Complaint #2020017328 was substantiated at N0025 and N0165 Complaint #2020005319 was substantiated at N0025 and N0165 The following is description of the deficiencies.	A 000		
A 025 SS=D	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	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 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 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 staff interview, record review, and facility policy the facility failed to provide supervision to prevent by failing to evaluate the potential for and failing to ensure appropriate interventions were in place to prevent for two residents (Resident #1, and Resident #5) of five residents surveyed for . The lack	A 025		

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A 025	Continued From page 2 of ensuring appropriate interventions to prevent had a potential to contribute to Resident #1 falling and injuring her and that caused her to be admitted to the hospital and transferred from the hospital to a rehabilitation facility, and Resident #5 falling and fracturing her The findings included: The facilities' " Management Policy" effective and last revised in 2018 shows the facility has put universal interventions for all residents. The policy reads, "A risk evaluation is completed at the time of move in/admission ... Residents who sustain a should have a post evaluation completed to consider-possible interventions to reduce the potential for future and injury." 1. A risk identification evaluation dated showed Resident #1 had a history of falling prior to moving into the facility. At the time the resident moved in she was taking , , medications, medication, and , medication. The resident was having problems ambulating and transferring and was unsteady when ambulating. The incident log showed Resident #1 had at the facility 3 times without injury on , , and . Review of Resident #1's Personal Service Plan dated showed Resident #1 was alert and oriented. The service plan showed the resident had within 12 months without apparent injury. Resident #1 was using a walker as a mobility aide. The service plan list the facilities universal precautions for all facility residents.	A 025		

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A 025	Continued From page 3 No additional prevention interventions were listed on the service plan. A progress note dated at 4:57 a.m. indicated, "Resident in bedroom floor- was not witnessed. She was observed lying on her right side near the wall. She had on as well as a large on her L [left] . First aid was applied. kept -Son accompanied her to Urgent care to see if stiches would be needed." A Physician's progress note dated indicated, " female presents after a ground level , alerted on arrival in triage. team at bedside on initial evaluation. Initial concern with injury, left injury, , injury other. Given her use of . The Team agrees to admit at this time for close observation." On at 1:19 p.m., the Wellness Director verified there had not been any investigation of the resident's on . No post evaluation was completed at the time of the . The Wellness Director said she believed the resident had out of her wheelchair but verified there was no documentation that this had occurred. The Wellness Director verified there had been no post evaluation completed when the resident had previously on . The Wellness Director said the resident was only ambulating with a walker when her son was walking with her. She said the resident was getting around most of the time in her wheelchair. The Wellness Director verified the resident was declining in her ability to ambulate without assistance at the time of her on .	A 025		

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A 025	Continued From page 4 2. Resident #5 was admitted to the facility on . Resident #5's 1823 dated showed the resident was a high risk when she was admitted to the facility. She needed assistance with toileting and transferring. Review of Resident #5's Personal Service Plan for showed she had the facility's universal precautions listed as prevention interventions. No other interventions to prevent was listed. A progress note dated at 8:45 a.m. indicated, "Resident out of bed on the overnight shift, care associates helped her to bed. When arriving, went in to check on resident and she stated that she could not move, and she was in a lot of ." A progress note dated at 4:54 p.m. indicated, " ...resident will be going to ...rehab for post yesterday resulting in a non- , of her ". On at 1:48 p.m., the Wellness Director said she could not find a evaluation completed on Resident #5 when she was admitted. The Wellness Director verified there was no post evaluation completed when the resident on . The Resident was readmitted to the facility on and there have been no additional interventions put in place to prevent further . The Resident was evaluated by staff to be a level 3 risk. The Wellness Director verified residents with a high risk currently have no interventions assessed other than the facility universal precautions. 3. On at 2:40 p.m., Staff E Licensed Practical Nurse (LPN), said she was not aware of any place where interventions were listed for residents. She said she looks at the 1823 when	A 025		

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A 025	Continued From page 5 she needs to find out information about the residents in the facility. She stated she was not aware of any residents currently determined a level 3 risk receiving any addition interventions to prevent . She verified the facility staff do not currently have a system for communicating residents at high risk for other than verbally. On at 2:49 p.m., Staff F, LPN said she was not aware of any place were prevention interventions are listed in the facility for any residents including residents at high risk for . On Staff G Medication Technician, said she was not aware of any current residents in the facility that were a high risk. She said if there was a resident that was a risk if would be communicated to her by verbal communication at shift change. She said the residents that have walkers and canes usually do for themselves and residents using wheelchairs to get around need more assistance with their needs. On at 4:15 p.m., the Administrator and Wellness Director verified the facility needed to ensure evaluations were completed at resident admission. Post evaluations should be completed with interventions to prevent further and residents with risk for should be communicated to staff with the interventions that are in place for the residents. Class III	A 025		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality	A 165		

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A 165	Continued From page 6 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 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	A 165		

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A 165	Continued From page 7	A 165		

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 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

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A 165	Continued From page 8 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 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 family and staff interview and record review the facility failed to report the adverse incidents of 2 residents (Resident #1 and #5) of 3 residents surveyed for . . with injury. Both residents at the facility and were transferred to a higher level of care after the . . Resident #1 suffered a and injury and was admitted to the hospital due to being on . . . . , she then was transferred to rehabilitation. Resident #5 . at the facility and was transferred to the hospital with a	A 165		

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A 165	Continued From page 9 The findings included: A risk identification evaluation dated showed Resident #1 had a history of falling prior to moving into the facility. At the time the resident moved in she was taking medications, medication, and medication. The resident was having problems ambulating and transferring and was unsteady when ambulating. The incident log showed Resident #1 had at the facility 3 times without injury on , , and . Review of Resident #1's Personal Service Plan dated showed Resident #1 was alert and oriented. The service plan showed the resident had within 12 months without apparent injury. Resident #1 was using a walker as a mobility aide. The service plan lists the facilities universal precautions for all facility residents. No additional prevention interventions are listed on the service plan. A progress note dated at 4:57 a.m. indicated, "Resident in bedroom floor- was not witnessed. She was observed lying on her right side near the wall. She had on as well as a large on her L [left] . First aid was applied. kept -Son accompanied her to Urgent care to see if stiches would be needed." A Physician's progress note dated indicated, " female presents after a ground level , alerted on arrival in triage. team at bedside on initial evaluation. Initial concern with injury, left injury. , injury other. Given her use	A 165		

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A 165	Continued From page 10 of . . . . . The . . . Team agrees to admit at this time for close observation." On . . . . at 4:00 p.m., Resident #1's son said his mother was transferred to a skilled nursing facility for rehabilitation after she was discharged from the hospital. On at 1:19 p.m., The Wellness Director verified there had not been any documented investigation of the Resident's on . The Wellness Director verified the Resident was alert and oriented at the time of the . There was no documentation as to the Resident reporting how she . There was no documentation of an interview with the caregiver assigned to the Resident as to how she was found and when she was last seen prior to the . On at 10:30 a.m., the Administrator said an investigation for . . . . . had been completed by the state agency after the Resident and was sent to the hospital. The Administrator verified there had been no adverse incident filed after the incident. 2. Resident #5 was admitted to the facility on . Resident #5's 1823 dated showed the resident was a high . risk when she was admitted to the facility. She needed assistance with toileting and transferring. Review of Resident #5's Personal Service Plan for shows she had the facility's universal . precautions listed as prevention interventions. No other interventions to prevent . . was listed. A progress note dated at 8:45 a.m. indicated, "Resident out of bed on the	A 165		

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A 165	Continued From page 11 overnight shift, care associates helped her to bed. When arriving, went in to check on resident and she stated that she could not move, and she was in a lot of ." A progress note dated at 4:54 p.m. indicated, " ...resident will be going to ...rehab for post yesterday resulting in a non- , of her ". On at 1:48 p.m., the Wellness Director said she could not find a evaluation completed on Resident #5 when she was admitted. The Wellness Director verified there was no post evaluation completed when the resident on . The Wellness Director verified there had been no investigation as to an interview with the resident, or staff assigned to the resident at the time of the . On the Administrator and the Wellness Director verified there had been no adverse incident filed when the resident and her , at the facility. Class III	A 165		