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
	AL11968751	A. BUILDING: _____ B. WING _____	06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT RIVERVIEW (THE)	8451 US HIGHWAY 301 SOUTH RIVERVIEW, FL 33578

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A 000	Initial Comments A Complaint investigation (# 2021007518 and #2021006627), COVID-19 focused control survey and generator monitoring visit was conducted at Crossings at Riverview on . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=J	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 accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:	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) 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 interviews, the facility failed to provide the personal supervision and oversight required for each resident to include awareness of general health, safety, and well-being for 1 (Resident #1) of 24 residents on the facility's memory care unit. This lack of oversight and awareness led to Resident #1's hospitalization after prolonged exposure to outside temperatures over 90 degrees Fahrenheit in the facility's memory care courtyard and placed all 24 residents of the memory care unit at immediate risk of harm.	A 025		

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A 025	Continued From page 2 Findings Included: Record review conducted on [redacted] revealed Resident #1 was admitted to the facility on [redacted]. Resident #1 was diagnosed with [redacted], high [redacted], memory [redacted], and [redacted]. On [redacted], a review of Resident #1's records revealed that on [redacted] at 3:40pm, Resident #1 was found by Staff A in tall grass just off the edge of the walkway of the facility memory care courtyard. Resident #1 was laying on her [redacted], slightly turned to the left, [redacted] slightly bent at [redacted] and in alignment. Resident #1 was unresponsive, breathing, [redacted] slightly closed and radial [redacted] rate approximately 64. The records revealed that staff called 911 and Emergency Medical Service ([redacted]) arrived and transported the resident to the local hospital. Review of the hospital records, conducted on [redacted], revealed, on [redacted] Resident #1 was transported to the Emergency Room (ER) via [redacted] from local facility and arrived at 5:29pm. Resident #1 was found in the bushes outside of the facility and had bradypnea (an abnormally slow breathing rate) with [redacted] of 10, severe hyperthermia (abnormally high body temperature), and was unresponsive. Resident #1's [redacted] was [redacted] and she had [redacted] (a fast, abnormal rate). The facility had been looking for Resident #1 for about 2 hours. Resident #1's temperature upon arrival at the ER was 105.9 Fahrenheit, her condition was severe, and not improving even after [redacted] provided cool ( ) [redacted] fluids . Further review of the ER report revealed the clinical diagnosis included [redacted] with an LMA ([redacted] mask airway) and prolonged heat	A 025		

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A 025	Continued From page 3	A 025		

exposure. The nature of the circumstance was prolonged heat exposure, symptoms were not improving, and degree was severe. She had a GCS scale of 3 (The Glasgow Scale is the summation of scores for , verbal, and motor responses. The minimum score is a 3 which indicates deep or a - state) and was intubated.

On /20201, record review of Resident #1's hospital discharge summary, dated , revealed Resident #1 was diagnosed with , acute hypoxemic failure, lactic acidosis (is low and too little is reaching the body's tissues), acute and
In a review of the accuweather.com for the facility's location, conducted on , revealed that the temperature on was 93 degrees Fahrenheit with a heat index of 101 degrees Fahrenheit.

Review of the Medication Observation Record for Resident #1, conducted on , revealed that Resident #1 had daily temperature and checks scheduled for 8am-10am. Resident #1's daily temperature in ranged from 96. degrees Fahrenheit and her saturations ranged from 94-98%.
A review, conducted on , found, according to the Florida Department of Health - Vital Statistics and Florida Agency for Health Care Administration (floridatracking.com/healthtracking/topic.htm?i=1 3) in 2019 Hillsborough County had over 100 heat-related hospitalizations and 428 heat-related ER visits. This number will continue to rise as the years go on due to rising temperatures.

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A 025	Continued From page 4 During a review of the National Institute of Environmental Health Sciences (https://www.niehs.nih.gov/research/programs/geh/climatechange/health_impacts/heat/index.cfm#:~:text=Prolonged%20exposure%20to%20extreme%20heat,%2C%. %2C%20and%20car %), conducted on with review date of , section titled, "Effects of Heat" stated that prolonged exposure to extreme heat can cause heat exhaustion, heat cramps, heat , and , as well as exacerbate pre-existing conditions, such as various , , , and . During an interview conducted on at 10:32 am. Staff E stated that this is her first day working in the memory care unit as a Resident Aide. She normally does not work in the memory care unit, but she was told to come down today because they were short of staff in memory care. In an interview conducted on at 10:48am with Staff A, the employee stated that Resident #1 was not in her around 4pm. She went to look for Resident #1 and could not find her. All of the staff started looking for her, that is when I came outside to the patio and saw her in the courtyard inside the bushes. She was unresponsive (would not respond to her name). The fire fighters arrived around 4:15pm. They removed her from the bushes & she was still unresponsive at that time. She could not talk or walk. They placed her on the stretcher at that time and transported her to the hospital. Staff A stated, she was told by the Director of Memory Care that she needed to start doing 15 minutes checks for Resident#1 now that she was from the hospital. She stated, it is	A 025		

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A 025	Continued From page 5 impossible to do 15 minutes checks, so she told the Director of Memory Care she could check on all residents every 2 hours. An attempted record review was conducted on revealed there was no policy or procedure in place to monitor residents in the courtyard. On at 11:10 am during an interview with the Executive Director (ED), the ED stated the following: *Resident #1 was able to get herself out (go outside), because they are free to go out. *Resident #1 was last seen at 2pm during the 2-hour count. *On at 3:40 p.m. staff reported Resident #1 was observed in courtyard, found on the ground and that is the only reason she was sent to the hospital, not because she was missing. *She stated the facility was doing headcounts on all shift changes and added 2-hour checks. They are not required to increase any checks. *The facility did not know if Resident #1 . She had a temperature of 106 degrees Fahrenheit, and she was not herself. She was sent to the ER at a local hospital. She was sent out just because she had a temperature, and it was hot outside. During an interview conducted at 11:52 am, with the Director of Health and Wellness, she stated the following: *The staff saw Resident #1, they found her outside, and she is a walker. *She did have a temperature of 106 degrees at 3:45 pm. *She was called at 3:45pm when Resident #1 was found unresponsive. She assessed Resident #1 and knew they needed to call 911, Resident #1	A 025		

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A 025	Continued From page 6 was very [illegible]. *It was not unusual for residents to go outside on the patio. Resident #1 was last checked at 2pm. *There were three staff to include one medication technician and two resident aides on that shift that day in memory care. *We asked the staff to check on her every 15 minutes now that she is in the facility. Attempted record review was conducted on [illegible] and revealed there was no documentation that staff checked on Resident #1 every 15 minutes. In an interview conducted on [illegible] with the Director of the Memory Care at 1:35pm, she said that the staff are not offering the residents water right now because they just had lunch. In an observation conducted on the Memory Care Unit on [illegible] beginning at 1:00pm, there was an automatic door from the common area that opened to a screened-in porch with cushioned chairs, sofa and two ceiling fans. The screened-in porch had two doors, one on either side that opened out to the courtyard. The courtyard area adjacent to the porch included a modified horseshoe shaped area and had rocking chairs. There is a cement walking trail between the courtyard and the building. The area between the building and the walking trail is lined with bushes and other shrubbery. In the center of the courtyard is a metal fence housing a garden type area. The entire area was enclosed by a cement fence. The only areas visible by staff from inside the facility in the memory care's common area were directly straight out to the screened porch or rocking chairs, directly in front of the facility door's line of sight. The area on the sidewalk that extends out to the left to the walking trail was not	A 025		

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A 025	Continued From page 7 visible when inside the common area and can only be viewed when outside in the screened in patio area or the courtyard area beyond. During an observation conducted on [illegible] at 1:00pm, Resident #2 was observed in the courtyard in a rocking chair in the covered area outside the screened in patio on the Memory Care unit. During an interview conducted on [illegible] at 1:00pm, Resident #2 stated he sits outside each day and the staff do not offer him anything to drink while he is outside. Resident #2 was observed coming [illegible] inside by himself at 1:10pm. There were no staff observed checking on the resident while he was in the courtyard and no staff were observed offering him hydration. An interview was conducted with Staff F on the Memory Care Unit on [illegible] at 1:15pm. When asked if the staff provided hydration when residents were outside in the heat, she replied that water was available in the front of the fridge. When asked if the residents are [illegible], able to get water themselves from the front of the fridge, she then replied that the staff have to give them water. In an observation during an interview with Resident #1 on [illegible] at 1:22pm, Resident #1 had Telfa [illegible] on the top of both of her [illegible] and what appeared to be a dried [illegible] on the left side of her upper [illegible]. During an interview conducted on [illegible] at 2:12pm, the Administrator stated that they tried the hydration station but said they cannot do it due to the residents touching it and putting their [illegible] in it. The facility offered fluids at 10am, 2pm and at mealtimes. There was no other written procedure or schedule for monitoring or	A 025		

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A 025	Continued From page 8 documenting the whereabouts or condition of the residents. In an interview conducted with Resident #1's family member on at 3:47pm, the relative stated the facility told him they could not keep the residents from going outside because they were allowed freedom and have the right to go out. He stated he spoke with the Director of the Memory Care unit, and she gave him no concrete details on any changes they would be making, but they would keep a close . . on Resident #1 and increase checks on her. He asked the facility why there were not security cameras or security buzzers on the doors, and they said that is a good idea. Resident #1's family member stated he was really upset that, with a relatively small facility courtyard how his family member could go out there lay out for hours and get . . . . . all over their arms from the sun. He said the ER doctor said there was no way possible Resident #1 was only outside for a few minutes and that it was more like 2 hours. Resident #1 was not responsive and was on life support when she was admitted to the hospital. It was dire and the family thought we had lost her. Class I	A 025		