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
	AL11969703	A. BUILDING: _____ B. WING _____	09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIANA OF SARASOTA	2630 UNIVERSITY PARKWAY SARASOTA, FL 34243

(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 #2021008842 was conducted on [redacted] at Liana of Sarasota, an assisted living facility in Sarasota, Florida. Complaint #2021008842 was substantiated at citation A025. The following is a description of the deficiency. .	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 [redacted] or [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 must notify the resident's representative or designee of the need for health care services and must assist in making [redacted] 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 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.	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 (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 record review, and staff interview, the facility failed to provide adequate supervision and failed to maintain a general awareness of the resident's whereabouts for 1 (Resident #1) of 3 resident records reviewed. Failure to maintain adequate supervision and awareness of whereabouts allowed Resident #1 to be unaccounted for from 5:00 p.m. on until 8:00 a.m. on when the resident was found outside laying on the ground in the gated	A 025		

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A 025	Continued From page 2 courtyard. The findings included: On . . . . . , record review of the resident progress notes for , revealed Resident #1 was found outside lying in the courtyard of the facility. Review of further documentation in the facility Resident Incident Report revealed on Resident #1 was found lying outside in the secured courtyard of the community. Interview on at 10:07 a.m., medication tech/Licensed Practical Nurse (LPN) Staff C she said on the Monday she came on duty and requested a report of the residents that and was told by staff Resident #1 was out of the facility with her daughter. Staff C said she knew Resident #1's daughter never took her out of the facility, so she started searching the facility and found Resident #1 outside lying in the courtyard in the dirt next to the bushes. She said Resident #1 would not be able to go out into the courtyard on her own as the door requires a code to open, she would not be able to get into the facility by herself. She said the resident was soiled, dirty and her nails contained dirt as she was lying in the dirt, and she is not sure how long Resident #1 was lying outside. On , record review of the Medication Observation Record (MOR) revealed all 5:00 p.m. and 8:00 p.m. medications for . . . . . were signed and circled by facility staff indicating the medications were not given, and on the . . . of the MORs documented the reason for not giving the medication as "out on pass." Interview on at 11:50 a.m., the Director of	A 025		

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A 025	Continued From page 3 Nursing (DON) she said Resident #1 is a risk and precautions are in place for her, including keeping Resident #1 in sight of staff at all times and performing 2-hour checks for Resident #1 when in her room. Interview on at 12:33 p.m., the Executive Director she said all facility sign in and out sheets had been destroyed, they are destroyed every 2 months. The Executive Director confirmed she had no documentation that shows Resident #1 was signed out of the facility by her daughter. Interview on at 12:35 p.m., the DON said she is not sure how Resident #1 was able to go outside in the courtyard without staff knowing as the door requires a code to open for access. She was not sure how long Resident #1 was outside in the courtyard before being found. The DON said there was no documentation to show that staff were doing the 2-hour checks when Resident #1 was in the room. Record review of the Department of Children and Families (DCF) recommendations for the facility are to include: 1. 2-hour check forms signed and/or initialed by staff for every shift. 2. Checks to be completed by staff after every shift to ensure all residents are accounted for. 3. Set a protocol in place in the event a resident is unaccounted for (call supervisor/executive director/law enforcement/family/NOK [next of kin]) 4. Have a sign out book for residents' family and staff to sign/initial. Inform oncoming staff if the names of the residents who are out of facility. 5. Put cameras in the outside secured courtyard. 6. Install an alarm and/or latch on the door to the secured courtyard to ensure the door is secured at all times.	A 025		

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A 025	Continued From page 4 Interview on at 1:24 p.m., the Executive Director said she did not implement the recommendations given by DCF including the forms for the 2-hour checks of residents for staff to sign as recommended by DCF. She told staff to check the residents visually and perform 2-hour checks. She confirmed there was no documentation to show checks performed by staff every 2 hours. She said staff never checked sign in/out sheets or called Resident #1's daughter to verify if she was with her. She verified there were no cameras outside in the secured courtyard and no alarms on the doors to the secured courtyard. Interview on at 2:24 p.m., medication tech/caregiver Staff E said on . . . . . when she came to work at 2:00 p.m., she did not see Resident #1 in the facility, and she did not go looking for her throughout her shift. Staff E said she went looking for Resident #1 at the time for her medications and did not find Resident #1 and signed the Medication Observation Record (MOR) as medication not given as Resident #1 "was out on pass." Staff E said she found out the following day on that Resident #1 was found outside lying in the courtyard. Interview on . . . . . at 2:42 p.m., caregiver Staff F said on during her shift she did not see Resident #1 and she did not look for her. She checked her bed at bedtime and it was still made but did not call Resident #1's daughter to verify she was with her. Interview on at 2:59 p.m., medication tech/caregiver Staff H said on . . . . . they were told the resident was out with her daughter, and she does not recall who said it. Staff H said she checked her room later and saw the bed still	A 025		

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A 025	Continued From page 5 made, she did not check to see if Resident #1 was signed out of the facility by her daughter. Interview on at 4:00 p.m., Resident #1's daughter said for the entire time her mother lived at the facility (to) she never took her out of the facility as she had issues with her eyesight and was unable to see well. She said she never received any call from the facility staff on . Class II .	A 025		