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 _____	R 03/29/2022

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 third revisit survey was conducted on [redacted] at Brookdale Phillippi Creek, an assisted living facility in Sarasota, Florida. This survey was done in conjunction with a complaint survey. This was a third follow-up to the complaint survey completed on [redacted]. The following deficiencies remain uncorrected A0025 Resident Care - Supervision and A0165 Risk Management and Quality Assurance - Adverse Incident Report. The following is a 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 shall 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 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.	{A 025}		

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{A 025}	Continued From page 1 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 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 review, the facility failed to provide supervision to prevent by failing to evaluate the potential for and failing to ensure post evaluations were completed after with	{A 025}		

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{A 025}	Continued From page 2 appropriate interventions in place to prevent reoccurrence of for 3 (Residents #15, #16, and #18) of 3 residents reviewed for . . . The findings included: The facility's " Management Policy" effective and last revised in showed the facility had 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.....A post evaluation is completed after a resident , individualized interventions are considered, and the evaluation is a part of the resident record". The facilities Prevention and Management - 32 Clinical Guidelines Issued , and last revised , 2018 indicated in addition to the Universal Precautions applied to all facility residents, Level 2 or a Level 3 additional interventions for consideration related to the resident's individual medical condition, functional status, environmental factors and safety awaerness. The facilities Risk Evaluation form indicates a resident with a without injury in the last twelve months is a Level 2 Risk and a resident with vision would be considered a Level 3 Risk. 1. Review of the facilities incident log on revealed Resident #15 had a on was found with a hematoma, forehead redness, and which resulted in transfer to the hospital.	{A 025}		

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{A 025}	Continued From page 3 Progress notes in Resident #15's chart dated . . . . . read: "resident found on floor with hematoma to forehead. Unable to recall what happened due to . . . . . ." Review of Resident #15's admission . Risk Assessment which was dated . The section under Level 3 . Risks had been completed with answers indicating she met criteria for a Level 3 . risk. The section under Level 3 Risks which asks if resident had any vision . . . . indicated yes. The section which asks if the resident appear unsteady when ambulation indicated yes. The form indicated Resident #15 was a Level 3 risk. There was no post evaluation with interventions completed for the . to prevent reoccurrence. Review of hospital Documents review report dated . . . . . read: "This is a . . , ... female who arrives as a level 2 alert after a ground level . . Per . . , staff at her facility report that she felt last night and that this was unwitnessed. They report they identified right deformity and a forehead hematoma this morning and decided to call . . ." There was no documentation of an investigation to determine what occurred with the resident and no adverse incident filed with AHCA. On . . . . . at 2:29 p.m., the Health and Wellness Director (HWD) confirmed no adverse incident was filed with AHCA. On at 4:00 p.m.,, Staff D stated she found Resident #15 with the hematoma and	{A 025}		

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{A 025}	Continued From page 4 . . . . . and would not be able to get herself off the floor if she , and she never asked anyone if Resident #15 had . . . 2. Review of the facility's incident log on . . . . . revealed Resident #16 had a on , resulting in . . . . to right . . and hematoma to right temple, resulting in a transfer to the hospital. Resident unable to explain what happened due to diagnosis of . Progress notes in Resident #16's chart dated . . . . . read: "Resident found on floor on left side. She has a on her R [right] and hematoma to R temple. Resident sent to SMH via 911." Review of Resident #16's admission Risk Evaluation which was dated . . . . . The section under Level 3 Risks had been completed with answers indicating she met criteria for a Level 3 risk. The section under Level 3 Risks which asks if resident had any vision . . . . . indicated yes. The section which asks if the resident appear unsteady when ambulation indicated yes. The section which asks does the resident have a history of . . . . decline indicated yes. The form indicated Resident #16 was a Level 3 . risk. There was no post . evaluation with interventions completed for the to prevent reoccurrence. 3. Review of facility incident log incident on revealed Resident #18 was found on the floor . . . down on . . . . . A Hematoma (bad .) was noted to right side of the with minimal . . . . . noted, and 2 . . . . to the right . . . . 911 was called and Resident #18	{A 025}		

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{A 025}	Continued From page 5 was transported to the hospital via ambulance for further assessment. There was no post evaluation with interventions completed for the to prevent reoccurrence. On at 5:50 p.m., the HWD confirmed no post evaluations were completed for Residents #15, #16 and #18 after having to prevent reoccurrence of . Class III	{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 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 ;	{A 165}		

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{A 165}	Continued From page 6 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 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	{A 165}		

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{A 165}	Continued From page 7	{A 165}		

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 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

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{A 165}	Continued From page 8 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 staff interview, the facility failed to report within 1 business day after the occurrence of an adverse incident, a preliminary report and provide within 15 days a full report including investigation of the incident to the Agency for Healthcare Administration (AHCA) for 3 (Residents# 15, #16 and #18) of 4 residents surveyed for with injury and transfer to more acute care. The findings included: 1. Review of facility incident log incident on revealed Resident #18 was found on the floor down on . A Hematoma (bad) was noted to right side of the with minimal noted, and 2 to the right . 911 was called and Resident #18 was transported to the hospital via ambulance for further assessment. A review of adverse incidents showed none had been filed with AHCA for this incident. On at 4:42 p.m., the District Director of Clinical Services said a trip to the Emergency Room is not a higher level of care, it is just an assessment. District Director of Clinical Services said reporting all ER visits would be a lot of work but if that is how the regulation is read, she would do it. 2. On , review of the facility incident log revealed Resident #15 was found with a hematoma, (bad), redness to forehead,	{A 165}		

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{A 165}	Continued From page 9 . . . ◡ to right . . on . . . . . 911 was called and Resident #15 was transported to the hospital via ambulance for further assessment. A review of adverse incident showed none had been filed with AHCA for this incident, and no documentation of an investigation was completed by facility staff and management. 3. On , review of the facility incident log revealed Resident #16 was found on floor on left side with a hematoma (bad ◡) on right temple, and . . . . . on right . . . . on . . . . . 911 was called and Resident #16 was transported to the hospital via ambulance for further assessment A review of adverse incident showed none had been filed with AHCA for this incident. On . . . . . at 2:29 p.m., the Health and Wellness Director (HWD) stated she completed an investigation after Resident #15 was transferred to the hospital, she confirmed there is no documentation of the completed investigation, and no adverse incident was filed with AHCA. . On at 4:39 p.m., the District Director of Clinical Services said if a resident goes to the hospital and return the same day, they don't complete an adverse incident as the resident is not treated at the hospital they are only being assessed. Class III	{A 165}		