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
	AL11964952	A. BUILDING: _____ B. WING _____	09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS (SARASOTA)	5509 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 A complaint survey was conducted at Arden Courts of Sarasota on through for complaint investigation # 2026012631 Deficiencies were identified at the time of the survey. Class I deficiencies were found at tag A025, A030. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate correction is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. The facility failed to provide adequate supervision for , residents when outdoors in the courtyard during extreme weather with heat indices above 100 degrees Farenheit (F) to protect them from extreme health related conditions. The facility failed to honor residents' rights for a safe, decent living environment free from harm of being locked outside of the facility during inclement weather and extreme temperatures with lack of staff monitoring. Failure to provide adequate supervision resulted in prolonged exposure to sun and extreme heat resulting in transfer to acute care facility. The noncompliance began on . The census at the start of the survey was 40. Deficiencies were identified at the time of the visit.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision	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 1 429.26 (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 Resident Care Standards. 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	A 025		

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A 025	Continued From page 2 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 interview, the facility failed to provide adequate supervision for , residents when outdoors in the courtyard during extreme weather with heat indices above 100 degrees Farehnheit (F) to protect them from extreme heat related health related conditions. This failure to provide adequate supervision resulted in serious harm to Resident #2 from prolonged exposure to sun and extreme heat resulting in transfer to acute care facility and resulted in Resident #1 being locked outside in the courtyard during extreme heat temperatures which had the potential to result in serious harm or . The findings included: 1. Review of facility records revealed on , at approximately 1:15 p.m., Resident #2 was found unresponsive outside near the facility far south gate. Resident #2 was brought inside the facility and cooling measures implemented with	A 025		

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A 025	Continued From page 3 ice packs to the forehead, , and underarms. At approximately 1:20 p.m., Staff C Licensed Practical Nurse (LPN) checked Resident #2 and reported a temperature of 105 degrees Fahrenheit and a faint . emergency medical Services ( ) was summoned. Resident #2 was transported to the local Hospital, intubated, admitted to the unit and subsequently transferred to the ( ). Review of Resident #2's record revealed an admission date of . Diagnosis included Unspecified , - , , , , , , and unspecified hearing loss. Review of the progress notes for Resident #2 indicated on , Staff A found Resident #2 outside in the courtyard by Berry Ridge unit on her and unresponsive. The nurse was called to the area. Resident #2's skin was red, and hot to touch, with redness to BLE (lower extremities). Resident #2 was noted to have a large hematoma on the right cheek/orbital area. Resident #2 was picked up and put into a wheelchair and brought indoors. compresses were applied to , , of , armpits, and forehead. 911 was called by this nurse, paramedics arrived within 5 minutes. Resident #2 was transferred to a gurney and taken to a local hospital. Resident #2 remained unresponsive when taken out of the building. Review of the "National Weather Service" revealed the temperature on at approximately 1:15 p.m.; the outside temperature was recorded at 94 degrees Fahrenheit, the Humidity was 63%, the Heat Index (feels like temperature) was 111.7 degrees F. Review of CDC (center for control)	A 025		

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A 025	Continued From page 4	A 025		

website ( ) noted that people or older are more prone to heat related health problems. Older adults do not adjust as well as young people to sudden changes in temperature. They are more likely to have a medical condition that changes normal body responses to heat. They are more likely to take prescription medications that affect the body's ability to control its temperature or sweat. https://www.cdc.gov/heat-health/risk-factors/heat-and-older-adults-aged-65.html

On at 10:35 a.m., during an interview, Resident #2's husband said his wife was admitted to the facility at the end of and was there for just a few weeks. He said he got a call on the afternoon of and the gentleman on the phone said they found his wife outside and were taking her to the ER. Resident #2's husband said when he got to the hospital his wife was in bad shape and barely breathing. He said that they had to put her in the for 3 days, put her in a , and intubate her. He said she came too after a few days but developed an that needed 3 separate surgeries over the next few weeks; she never recovered and was transferred into hospice where she three days later at the end of the month. He said he assumed the facility doors would be locked, and stated, "it was horribly hot during that period." Resident #2's husband said there should have been someone out there watching her pretty much the whole time she was out there in that heat.

On at 12:00 p.m., during a facility tour, all exterior doors to the courtyard were observed to be locked and alarmed.
The courtyard was observed to be a large area, surrounding the entire length and width of the outside of the building. There were several

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A 025	Continued From page 5 concrete walkways observed, surrounded by grassy areas, with benches scattered throughout. Doors to the courtyard were scattered throughout the 1 story facility, and visibility to parts of the courtyard were limited due to the location of the doors, resident rooms, the location of common area windows, and the overall size and scope of the exterior. Based on observation of the grounds, the entire courtyard would need to be to visually secure the entire area. On at 12:20 p.m., during an interview, Caregiver Staff B said on the day of the incident, the last time she saw Resident #2 was before lunch walking around. She said earlier that morning she tried to bring Resident #2 inside, but she refused. Staff B said she does not remember seeing Resident #2 eat lunch that day, and she does not recall documenting she saw Resident #2 at 12:45 p.m. that day because that was after lunch and she didn't see Resident #2 at lunch time. Staff B said she didn't think to go looking for Resident #2 because she was floating between 2 units, and she didn't know that she was even gone until she heard the commotion in the hallway, and then, she went to look for her but found out she was being taken out to the hospital. Staff B said she was asked by the nurse if she had seen the resident and was told that Resident #2 was supposed to be on 15-minute or 30-minute checks. Staff B said no one told her that until after the incident happened. On at 12:40 p.m., during an interview, Licensed Practical Nurse (LPN) Staff C said she was passing medications on , the day of the incident, she was not very familiar with Resident #2 but knew she was a , and to her knowledge, was on 1-hour checks. Staff C said sometime after lunch around	A 025		

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A 025	Continued From page 6 1:15-1:30, she received a call over the radio stating there was an unresponsive resident outside. She went outside and saw Resident #2 laying down ½ on the concrete and ½ on the grass on the south side of the facility courtyard. Staff C said Resident #2 was red, and hot, she and two caregivers got her into a chair and wheeled her inside, she took some readings (vital signs). Resident #2 was unresponsive, and she got a faint , . She said it wasn't strong and Resident #2 had an initial temperature of 105.1 F. She had the girls get ice and call 911. Staff C said she iced down Resident #2 and told what had happened when they arrived and they took over from there. Staff C said she knew the doors were unlocked although it was hot, and she was not sure if there currently was a policy or procedure on when to lock them. 2. Record review for Resident #1 revealed an admission date of , Medical diagnosis included , , ( ), D deficiency, , , , Hx (history) , with a or behavioral status of . On at approximately 12:50 p.m., during an observation of the courtyard area, Resident #1 was observed walking around in the exterior courtyard area. Resident #1 was wearing a sweatshirt, sweatpants and shrouded in a large blue comforter. Resident #1 was observed milling around near an exterior door outside in the courtyard. Resident #1 was outside with no means to reenter the facility from the courtyard as the exit doors required a code to be input to re-enter the facility. Resident #1's status/diagnosis did not allow her to convey her wishes to reenter the building. There was no staff	A 025		

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A 025	Continued From page 7 supervision of Resident #1 locked outside in the courtyard during hot afternoon weather; all exit doors were locked at this time, as all exit doors to the courtyard automatically locked at 12:00 p.m. Review of the "National Weather Service" revealed the temperature at the time was wwas recorded at 89 degrees Fahrenheit, the humidity was 70%, the Heat Index (feels like temperature was 103 F. On at 12:58 p.m., while looking for a facility staff member, Caregiver Staff D was observed walking by the door and happened to see Resident #1 outside the locked door. Staff D opened the door and guided Resident #1 into the building. Staff D did not check Resident #1 or call the nurse to check Resident #1 who was locked outside in the hot weather. Staff D guided Resident #1 to the activities room and exited the area. On at 1:02 p.m., during an interview, Staff D confirmed letting Resident #1 in, as she was locked out. Staff D said there should be hourly checks done on the residents and she is not sure what happened with Resident #1. She said the door was locked at noon, and she thinks Resident # , have been out there since before that, Staff D said if you push on the doors long enough (like 30 seconds) and an alarm goes off but the door will then open. Staff D said she was not sure how long Resident #1 was locked out in the courtyard or if she had lunch, because she was not her resident, as she works on the other side of the unit and was on break. Staff D said she did not hear an alarm go off. On at 2:05 p.m., during an interview, the Environmental Services (EVS) / Maintenance	A 025		

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A 025	Continued From page 8 Director (MD) said the courtyard doors today worked exactly how they were supposed to work. He said there is no announcement at noon about the locking of the doors, it happens automatically. The EVS/MD Director said a few folks got locked out a few weeks , and he did not remember who they were, but they were brought in. The MD stated, "There should be no residents outside between 12 and 4 p.m.. If there is a resident outside between p.m. at any time then we have a problem!" On at 12:20 p.m., during an interview, the Business Office Manager (BOM) said he was the acting Executive Director (ED) on and was in the front office, when he heard over the radio, "We need a nurse to the courtyard stat". The BOM said he could tell by the tone of the request something was different, and by the time he got there the staff had already brought Resident #2 inside. He said he guessed he got to the scene at about 1:20 p.m. The BOM stated, "I saw the resident in the chair; she was unresponsive, breathing heavily, and looked hot. The staff was icing her down, the nurse called and went into the office to grab a sheet and list of meds, I stayed with the staff and the resident during those few minutes." The BOM said he is not sure if the nurse took vitals, but (Emergency Medical Services) arrived at about 1:30 p.m. and they put Resident #2 on the gurney and took her into the parking lot. He stated, "I knew that it was bad". He said he then called the husband and said they found her out in the courtyard and they were taking her to a local hospital. The BOM said that he provided all the courtyard inclement weather policy training, he went over the policy, read through it, had the staff sign it and gave them a copy. He said he told staff as part of	A 025		

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A 025	Continued From page 9 the training courtyard exit the doors would locked temporarily from 12-4pm. The BOM said the training was done just for the staff that were working there at the time and no training was done for the new hires. The BOM said anyone hired after received no training about the inclement weather as it is not part of the orientation and onboarding, he provides to new hires. On , review of facility training records revealed documentation of training sessions for "Courtyard Monitoring Guidelines for Inclement Weather" on , , , and . 24 care staff members were documented as having completed the training. 19 current care staff members had no documentation for completion of the training. On at 1:46 p.m., during an interview, the Executive Director and the Senior Human Resource Director acknowledged Resident #1 was locked outside in the courtyard unattended at 12:58 p.m., 58 minutes after the exterior courtyard doors were locked and the only way to enter was through staff entering a code. Class I	A 025		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely	A 030		

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A 030	Continued From page 10	A 030		

accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C.
(b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
(c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and . ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard

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A 030	Continued From page 11 precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate	A 030		

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A 030	Continued From page 12 living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of	A 030		

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(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 030	Continued From page 13 medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or	A 030		

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A 030	Continued From page 14 special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and	A 030		

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A 030	Continued From page 15 his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review, observation and interviews, the facility failed to honor residents' rights for a safe, decent living environment free from the harm of being locked outside of the facility during inclement weather and extreme temperatures with lack of staff monitoring for 2 (Resident #1, #2) of 2 reviewed. Failure to ensure no residents are outdoors when the courtyard doors automatically lock has the potential to exposed residents to extreme temperatures which may lead to serious harm to the 40 residents residing in the facility. The findings included: Record review of the Courtyard Monitoring Guidelines for Inclement Weather Original Date: . . . Courtyard monitoring Guidelines are utilized to provide for the ongoing supervision and safety of residents who enjoy outdoor courtyards, walking paths, porches and other outside areas. . . GENERAL CONSIDERATIONS: 1. During inclement weather (E.G. thunder storms, elevated temperatures/heat indexes, snow storms, and cool temperatures) the	A 030		

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A 030	Continued From page 16 courtyard doors are alarmed to alter staff that a resident has entered the courtyard or the outside area. 2. All staff responds to door alarms immediately to determine which resident is outside and appropriateness of courtyard usage secondary to resident's abilities and weather conditions. 3. Nursing supervisor conducts walk through prior to locking courtyard . . . HEAT EXPOSURE GUIDELINES: . . . 2. Residents with . . , , , , communications, require with mobility or have poor decision making skills, are permitted to go outside and will be visually monitored by staff every 30 minutes." 1. On at 12:00 p.m., during a facility tour, all exterior doors to the courtyard were observed to be locked and alarmed. On at 2:05 p.m., during an interview, the Environmental Services (EVS) / Maintenance Director (MD) said the doors today worked exactly how they were supposed to work. He said there is no announcement at noon about the locking of the doors, it happens automatically. The EVS/ MD Director said a few folks got locked out a few weeks , but he did not remember who they were, but they were brought in. The MD stated, "There should be no residents outside between 12 and 4 p.m.. If there is a resident outside between p.m. at any time then we have a problem!" On at 10:20 a.m., during a facility tour, the courtyard was observed to be a large area, surrounding the entire length and width of the outside of the building. There were several concrete walkways observed, surrounded by grassy areas, with benches scattered throughout.	A 030		

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A 030	Continued From page 17 Doors to the courtyard were scattered throughout the 1 story facility, and visibility to parts of the courtyard were limited due to the location of the doors, resident rooms, the location of common area windows, and the overall size and scope of the exterior. Based on observation of the grounds, the entire courtyard would need to be to visually secure the entire area. On at approximately 12:50 p.m., during an observation of the courtyard area, Resident #1 was observed walking around in the exterior courtyard area. Resident #1 was wearing a sweatshirt, sweatpants and shrouded in a large blue comforter. Resident #1 was observed milling around near an exterior door outside in the courtyard. Resident #1 was outside with no means to reenter the facility from the courtyard as the exit doors required a code to be input to re-enter the facility. Resident #1's status/diagnosis did not allow her to convey her wishes to reenter the building. There was no staff supervision of Resident #1 locked outside in the courtyard during hot afternoon weather; all exit doors were locked at this time, as all exit doors to the courtyard automatically locked at 12:00 p.m. Review of the "National Weather Service revealed the temperature outside was recorded at 89 degrees Fahrenheit (F), the Humidity was 70%, the Heat Index(feels like temperature) was 103 degrees F. Review for Resident #1 revealed an admission date of . Medical Diagnosis included ( ), D deficiency, , Hx (history) , with a /Behavioral Status of . On at 12:58 p.m., while looking for a	A 030		

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A 030	Continued From page 18 facility staff member, Caregiver Staff D was observed walking by the door and happened to see Resident #1 outside the locked door. Staff D opened the door and guided Resident #1 into the building. Staff D did not check Resident #1 or call the nurse to check Resident #1 who was locked outside in the hot weather. Staff D guided Resident #1 to the activities room and exited the area. On at 1:02 p.m., during an interview, Staff D confirmed letting Resident #1 in, as she was just previously locked out. Staff D said the door was locked at noon, and she thinks Resident # , have been out there since before that. She said if you push on the doors for long enough (like 30 seconds) an alarm will go off and the door will then open. Staff D said she was not sure how long Resident #1 was out in the courtyard or if she had lunch, because she was not her resident, as she works on the other side of the unit and was on break, and did not hear any alarm. On at 1:45 p.m., during an interview Staff E (caregiver), said she had no formal training on the operation of the doors and didn't know of any procedure specifically about the doors, and they forgot to tell them when the doors are locked. Staff D said sometimes residents do get locked outside and they must find them out there. On , review of facility training records showed documented training sessions for "Courtyard Monitoring Guidelines for Inclement Weather" on , , , and . 24 care staff members were documented as having completed the training. 19 current care staff members had no documentation for completion of the training.	A 030		

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A 030	Continued From page 19 On at 12:20 p.m., during an interview, the Business Office Manager (BOM) said he provided the courtyard inclement weather policy training, he went over the policy, read through it, had the staff sign it and gave them a copy, and told staff as part of the training that the doors would be shut and locked from p.m. The BOM said the training was done just for the staff that were working there at the time and no training was done for the new hires and anyone hired after had no training about the inclement weather as it is not part of the orientation and onboarding provided to new hires. On , during an interview, the Senior Executive Director (ED) said staff should be doing sweeps in the courtyard, though the doors are locked. She said the Nurse on duty has responsibility to follow up to make sure the checks are being done, and the Resident Services Director is responsible for additional oversight. On at 1:46 p.m., during an interview, the ED and the Senior Human Resource Director acknowledged Resident #1 was locked outside in the courtyard unattended at 12:58 p.m., 58 minutes after the exterior courtyard doors were locked and would only be able to reenter with staff entering a code. 2. Review of facility records revealed on , at approximately 1:15 p.m., Resident #2 was found unresponsive outside near the facility far south gate. Resident #2 was brought inside the facility and cooling measures implemented with ice packs to the forehead, , and underarms. At approximately 1:20 p.m., Licensed Practical Nurse (LPN) Staff C checked Resident #2 and	A 030		

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A 030	Continued From page 20 reported a temperature of 105 degrees Fahrenheit (F) and a faint . Emergency medical services ( ) was summoned. Resident #2 was transported to a local Hospital, intubated, admitted to the unit and subsequently transferred to the ( ). Review of Resident #2's record revealed an admission date of . Diagnosis included Unspecified , , , , , and other and unspecified hearing loss. Review of the progress notes for Resident #2 indicated on , Staff A found Resident #2 outside in the courtyard by Berry Ridge unit on her and unresponsive. The nurse was called to the area Resident #2's skin was red, and hot to touch, with redness to BLE (lower extremities). Resident #2 was noted to have a large hematoma on the right cheek/orbital area. Resident #2 was picked up and put into a wheelchair and brought indoors. compresses were applied to , of , armpits, and forehead. 911 was called, paramedics arrived within 5 minutes. Resident #2 was put on a gurney and taken to a local hospital. Resident #2 remained unresponsive when taken out of the building. Review of the "National Weather Service revealed the temperature on at approximately 1:15 p.m., the outside temperature was recorded at 94 degrees Fahrenheit, the Humidity was 63%, the Heat Index (feels like temperature) was 111.7 degrees F. Review of CDC (center for control) website ( ) noted that people or older are more prone to heat related health	A 030		

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A 030	Continued From page 21	A 030		

problems. Older adults do not adjust as well as young people to sudden changes in temperature. They are more likely to have a medical condition that changes normal body responses to heat. They are more likely to take prescription medications that affect the body's ability to control its temperature or sweat. https://www.cdc.gov/heat-health/risk-factors/heat-and-older-adults-aged-65.html

On at 10:35 a.m., during an interview, Resident #2's husband said his wife was admitted to the facility at the end of and was there for just a few weeks. He said he got a call on the afternoon of , and the gentleman on the phone said they found his wife outside and were taking her to the Emergency Room. Resident #2's husband said when he got to the hospital his wife was in bad shape and barely breathing, they had to put her in the for 3 days, put her in a , and intubate her. Resident #2's husband stated, " it was horribly hot during that period," but there should have been someone out there watching her pretty much the whole time she was out there in that heat.

On at 12:20 p.m., during an interview, Caregiver Staff B said on , the last time she saw Resident #2 was before lunch walking around. She said earlier that morning she tried to bring Resident #2 inside, but she refused. Staff B said she does not remember seeing Resident #2 eat lunch that day, and she does not recall documenting she saw Resident #2 at 12:45 p.m. that day, because that was after lunch and she didn't see Resident #2 at lunch time. Staff B said she didn't think to go to look for Resident #2 because she was floating between 2 units, and she didn't know that she was even gone until she heard the commotion in the hallway, and then she

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A 030	Continued From page 22 went to look for her, but found out she was being taken out to the hospital. On at 12:40 p.m., during an interview, Licensed Practical Nurse (LPN) Staff C said that sometime well after lunch around 1:15-1:30, she received a call over the radio stating there was an unresponsive resident outside. She went outside and saw Resident #2 laying down ½ on the concrete and ½ on the grass on the South side of the facility courtyard. Staff C said when she got there Resident #2 was red, and hot; herself and two care givers got her into a chair and wheeled her inside. Staff C said she took some readings (vital signs). Resident #2 was unresponsive, with a faint , , and an initial temperature of 105.1 F. She had the girls get ice, and 911 was called. She iced down Resident #2 and told what had happened when they arrived and they took over from there. Staff C said she knew the doors were unlocked although it was hot, and she was not sure if there currently was a policy or procedure on when to lock them. Class I	A 030		