STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **105790**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **08/29/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARISTOCRAT, THE	**10949 PARNU STREET NAPLES, FL 34109**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview and record review the facility failed to develop and implement policies and procedures to ensure residents who utilize the outdoor courtyard area are not neglected. One (Resident #1) of 8 sampled residents sat in 90+ degree Fahrenheit weather in the direct sunlight for approximately 3 hours. As a result, he suffered acute injury from overexposure to sun, heat, and humidity. The resident's internal body temperature became overheated, and the resident became unresponsive. The resident was transported to the hospital emergency room with a [DIAGNOSES REDACTED]. Subsequently, Resident #1 expired 9 days later. Facility staff failed to offer the resident hydration or assist him out of the sun back into the air conditioning or shade. This failure created a situation that resulted in serious injury and harm to Resident #1, and required immediate corrective action on the part of the facility. The Immediate Jeopardy beginning on [DATE] was identified on [DATE]. The Immediate Jeopardy was abated on [DATE], based upon the implementation of corrective action. Four (Residents #1, #2, #6, and #7) of the 8 sampled residents were identified as going outside without supervision. The facility's census was 57 at the time of the survey. All residents who utilize the courtyard were at risk for neglect, illness/injury and even death. The facility began to put corrective actions in place after the resident was harmed on [DATE]. The corrective actions reduced the scope and severity to D (that is, isolated, no actual harm with potential for more than minimal harm). The findings included: Elderly people (that is, people aged [AGE] years and older) are more prone to heat stress than younger people for several reasons: Elderly people do not adjust as well as young people to sudden changes in temperature. They are more likely to have a chronic medical condition that changes normal body responses to heat. They are more likely to take prescription medicines that impair the body's ability to regulate its temperature or that inhibit perspiration. (source: Extreme Heat by Centers for Disease Control at <http://stacks.cdc.gov/view/cdc/ >) 1. Resident #1 was a [AGE] year old male who had been residing in the assisted living facility (ALF) attached to the skilled nursing facility (SNF). Review of clinical records showed his [DIAGNOSES REDACTED]. Recently he had lower extremity [MEDICAL CONDITION] (swelling due to excess fluid, a sign of heart failure) and was on [MEDICATION NAME] (a water pill) 40 milligrams twice a day. Both of his legs were wrapped with zinc-paste wraps. He was alert and oriented and able to make his needs known. He was a new admission so his comprehensive assessment and care plan were not completed yet. The medical progress note dated [DATE] documented, Resident was seen yesterday as he transferred to SNF from ALF d/t (due to) his increased debility and exit seeking from ALF. Presently up in his W/C (wheel chair) and he does self-propel in his W/C and he does like to sit outside in the sun but needs to be monitored. The Nurse Practitioner failed to write orders for monitoring the resident while outside in the sun. 2. Nursing note dated [DATE] at 4:46 p.m. documented, Patient (Pt) wanting to go outside. CN (charge nurse) showed Pt that there was thunder and lightning outside. Nurse tried to discourage Pt from going out. Pt very HOH (hard of hearing), deaf and did not hear nurse. Pt continued outside in the storm. Five days later, nursing note dated [DATE] at 7:28 p.m. documented, Pt was found outside by day CN and evening CN in his WC, unresponsive. Pt was not arousable, placed in his bed and vital signs taken. Temperature was 105 (very high). 911 was called while other nurses tried to cool Pt down with cold towels until EMS (emergency medical services) arrived. Pt taken to (name of hospital). Spouse notified and Dr. (doctor) notified. Upon transfer to the hospital on [DATE] at 5 p.m., the resident's vital signs were: temperature 105 degrees Fahrenheit (very high), blood pressure ,[DATE] (low), pulse 126 (high), and respirations 40 (high). Review of the emergency room care note dated [DATE] at 5:50 p.m. showed, patient is a [AGE] year old male presenting to the ED (emergency department) due to hyperthermia. EMS was called today after the patient was left outside for too long. EMS reports that the patient was left outside on his wheelchair for approximately two hours. Upon arrival his oral temperature was 102 and rectal 107. History is limited due to patient's clinical state. emergency room care note at 8:07 p.m. documents the resident went into [MEDICAL CONDITION], and CPR (cardiopulmonary resuscitation) was performed. The resident was intubated and placed into the intensive care unit where he remains as of today, [DATE]. 3. The recorded the temperature in Naples on [DATE] was 93.9 degrees Fahrenheit at 3:53 p.m. and heat index of 100.8 degrees Fahrenheit with no precipitation. (source: Weather Underground website at http://www.wunderground.com/history/airport/KAPF/[DATE]/DailyHistory.html?req_c) 4. During an interview on [DATE] at 10:32 a.m., the facility Medical Director said he would prefer to limit the time residents are outside. He said in order to prevent this from happening again, the residents need to be supervised. He said having water outside would not have made a difference for Resident #1. He said all the talk is about dehydration, but the Resident's problem was his temperature. He said the resident had a [MEDICAL CONDITION] at some point and that may have been why he was not able to bring himself back into the building. 5. During an interview on [DATE] at 1:18 p.m., the facility Administrator and the Director of Nursing (DON) said the outdoor video camera showed the resident entering the courtyard area at 1:52 p.m. He was in the shaded area for 2 minutes, then propelled himself out of the shade and into the direct sun. The video showed the Social Worker interviewing the resident at 2:53 p.m. The resident was outside until 4:57 p.m. The video camera shows the resident shifting himself around in the wheelchair. The DON said on the video you can only see the back side of the chair and a silhouette of the resident (photographic evidence presented is in the file). During an interview on [DATE] at 11:35 a.m., the Social Worker said she asked the resident questions. He was able to tell her the year, month and date and was able to repeat 2 of the 3 items she asked him to repeat. She then asked him some mood questions and he was able to answer them appropriately. She said he was sitting a little bit beyond the cover and his body was in the sun. Her conversation with the resident was on video at 2:53 p.m. During an interview on [DATE] at 11:41 a.m., Staff I said, At lunch time, probably around 10 minutes to 2, the resident was trying to propel himself through the dining room where other residents were eating. He was not able to get outside at this point and I heard someone tell him he needed to go back out in the hall so they could bring the other residents out of the dining room (photographic evidence presented is in the file). The next time I saw him, I was sitting at the nurses station, and (Staff A) was charting in the back room. She asked me if 'he was outside' and 'was it raining?' Staff I said, I got up to look out and saw (Resident #1) sitting outside. I told (Staff A), 'Yes, he is there and it is not raining.' This may have been around 4 p.m., I am not sure. Staff I continued, (Staff J), the ,[DATE] charge nurse (came in late around 4 p.m.) went into the assisted dining room around 4:30. I followed her into the dining room . I do not remember the whole conversation, but she mentioned 'him' and I said, 'I am going to bring him in.' He appeared to be sleeping. I went to put his feet on his foot rest, and when I did I saw he had mucous coming from his nose and drool from his mouth. I put his feet up on the pedals so I could bring him inside and noticed he was not responding. He was breathing slightly labored and I went to get a pulse oximeter to check his oxygen, and it was 92%. (Staff J) touched his skin and said he felt hot. I took him down the hall and other staff came into the room. We put him into the bed. Staff began wetting towels to put under his arms, groins and behind his neck, and his temperature was 105. I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0224

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 1)
think it was taken under his arm. Another nurse and I then took his shirt off, and at that point everyone kept changing the cloths to try and cool him down. We also elevated his feet because his blood pressure was low. He was then transported to the hospital. She said before this incident, the facility did not have a protocol in place to supervise residents in the courtyard or a hot weather protocol. During an interview on [DATE] at 12:04 p.m., Staff A said, I was the nurse assigned to the resident on [DATE]. I gave him his meds around 8:30 a.m., then tried to encourage him to eat a little more breakfast. Since he started on the [MEDICATION NAME] (an antidepressant medication) for the 'picking disorder' he has been sleeping a little more. I was told by the nurse practitioner that is was probably due to the [MEDICATION NAME]. He came down to my cart around a quarter to 12 and just sat there and waited by my cart. I took him to the main dining room around 12:15 p.m. and gave him 2 glasses of orange juice, soup and a cup of coffee. I went to lunch around 1:05 p.m. and came back around 1:35 p.m. and sat and charted for about 20 minutes. I saw him sitting outside of the door in the courtyard between 2 and 2:30 p.m. He was upright. I gave report to (Staff D), the evening nurse, around 3:10 or 3:15 p.m. and told her (Resident #1) was outside. I continued to chart and for some reason (I heard what sounded like thunder) I thought about Resident #1 and made the statement to (Staff I), '(Resident #1), isn't still setting outside is he?' Staff I went to check on him. He was hot, they brought him in, and he was not responsive. Staff A said, I was told by the assisted living facility that he liked to spend several hours a day in the sun. He has a history of wanting to be outside and once he was outside he did not want to come back in. Most of the other residents who go outside to the courtyard have family or a caregiver with them. 6. During an interview on [DATE] at 9:44 a.m., the DON said the facility staff was aware the resident liked to go outside. The staff was aware the resident would self-propel his wheelchair to sit in the sun. She said he was able to make his wants and needs known and would often yell for assistance. She said when the wife was called about his condition on [DATE] she commented, I bet he was out in the sun wasn't he? The DON said before this incident there was no process in place for monitoring and supervising residents in the courtyard. She said an outdoor protocol (for temperature >85 degrees) has been established since the incident. She said it was developed with the assistance of Medical Director. The staff have also been in-serviced on rounding on the residents at the change of shift and every 2 hours.

7. During interviews, Residents #2, #3, #4, #6, #7, and #8 indicated the facility did not provide drinks, sun protection, or supervision when residents are outside in the hot weather. 8. In an interview on [DATE] at 3:05 p.m., Resident #2 said, I go outside when they take me, not for very long, too hot. 10 or 15 minutes, that's all. 9. In an interview on [DATE] at 4:30 p.m., Resident # 3 said, I never go outside unless my family is with me; we just take a walk or something, and my daughter brings me drinks. I don't know if they would check on me; I don't go out. 10. In an interview on [DATE] at 2:52 p.m., Resident #4's spouse stated, We always sit in front of the building where we can be seen from the front desk. We don't go outside in this weather it's too hot. Resident #4 said she never goes outside alone. We go out when it is cooler. No one ever comes out and offers us water or lotion, but we don't usually stay out that long, maybe 15 minutes or so. I see people walking in and out of the building, but I don't think they are checking on us. 11. In an interview on [DATE], at 2:36 p.m. Resident #6 said she frequently goes outside to sit in the sun. I usually sit by the door so they can see me. No they never give us water outside; they give us water in our room. No, they never offer suntan lotion or a hat. I never see anyone come outside to check on me. 12. In an interview on [DATE] at 2:58 p.m., Resident #7 stated, Yes, I like to go outside, but I didn't go outside today. No, they never bring us drinks or ask if we want one when we go outside. We get that in here. No, they don't check on me when I go outside, but I usually go outside with a friend (another resident in the facility). I usually stay outside for about 30 minutes or so. 13. In an interview on [DATE] at 4:45 p.m., Resident #8 stated, I don't speak good English, just a little bit. I go out; too hot now. Don't know if they check, no drinks.

14. The skilled nursing facility is co-located with an assisted living facility (ALF). Resident #1 was admitted to the ALF on [DATE]. The staff there found the resident wanted to remain outside on their patio much of the time. In an interview on [DATE] at 2:40 p.m., an ALF Certified Nursing Assistant said they obtained sun screen from the resident's spouse for the resident to use daily. Upon rising the staff would apply the sun screen. The resident would put on his sunglasses and his hat and go outside. They assigned the activity person to go out and give the resident fluids every ,[DATE] minutes. They brought the resident inside the facility at various times throughout the day. The ALF Activity Person's responsibility was to check on the resident frequently. She brought Resident #1 ginger ale and snacks to ensure he would drink and eat. They had gotten Resident #1 a cup holder for his wheelchair so he would have a drink available at all times. In an interview on [DATE] at 3:00 p.m., ALF Registered Nurse Staff H said the resident had no concept of whether he was sitting in the sun or in the shade; he could not tell the difference. The SNF had no policy to address care of the residents when outdoors in hot weather which was confirmed in an interview with the DON (see above). 15. These systems failures created a situation resulting in critical harm for Resident #1 on [DATE]. See also citations at F271 (admit orders) and F490 (hazards). The facility began to put corrective actions in place after the resident was harmed. The Immediate Jeopardy was abated on [DATE] based upon the following corrective actions put into place by the facility: -Adopted policy entitled Resident Safety: Outdoor Monitoring Guidelines, -Installed a doorbell that rings upon exiting and entering the courtyard, -Placed a water cooler with cups in the courtyard, and -Assigned staff to monitor the courtyard area every 20 minutes. .

F 0271

Level of harm - Immediate jeopardy

Residents Affected - Few

Provide doctors orders for the resident's immediate care, at the time the resident was admitted.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based upon observation, interview and record review the facility failed to ensure residents had adequate orders for immediate care for 1 (Resident #1) of 8 sampled residents. Resident #1 had a history of [REDACTED]. The facility failed to have orders in place to provide care outside. As a result, he stayed outside overexposed to sun, heat, and humidity. He was hospitalized and subsequently expired 9 days. The facility's census was 57 at the time of the survey. The findings included: 1. Resident #1 was a [AGE] year old male who had been residing in the assisted living facility (ALF) attached to the skilled nursing facility (SNF). Review of records showed his [DIAGNOSES REDACTED]. Recently he had lower extremity [MEDICAL CONDITION] (swelling due to excess fluid, a sign of heart failure) and was on [MEDICATION NAME] (a water pill) 40
milligrams twice a day. Both of his legs were wrapped with zinc-paste wraps. He was alert and oriented and able to make his needs known. The medical progress note dated [DATE] documented, Resident was seen yesterday as he transferred to SNF from ALF d/t (due to) his increased debility and exit seeking from ALF. Presently up in his W/C (wheel chair) and he does self-propel in his W/C and he does like to sit outside in the sun but needs to be monitored. The Nurse Practitioner failed to write orders for monitoring the resident while outside in the sun. 2. Nursing note dated [DATE] at 4:46 p.m. documented, Patient (Pt) wanting to go outside. CN (charge nurse) showed Pt that there was thunder and lightning outside. Nurse tried to discourage Pt from going out. Pt very HOH (hard of hearing), deaf and did not hear nurse. Pt continued outside in the storm. Nursing note dated [DATE] at 7:28 p.m. documented, Pt was found outside by day CN and evening CN in his WC, unresponsive. Pt was not arousable, placed in his bed and vital signs taken. Temperature was 105 (very high). 911 was called while other nurses tried to cool Pt down with cold towels until EMS (emergency medical services) arrived. Pt taken to (name of hospital). Spouse notified and Dr. (doctor) notified. Review of the emergency room care note dated [DATE] at 5:50 p.m. showed, patient is a [AGE] year old male presenting to the ED (emergency department) due to hyperthermia. EMS was called today after the patient was left outside for too long. EMS reports that the patient was left outside on his wheelchair for approximately two hours. Upon arrival his oral temperature was 102 and rectal 107. History is limited due to patient's clinical state. emergency room care note at 8:07 p.m. documents the resident went into [MEDICAL CONDITION], and CPR (cardiopulmonary resuscitation) was performed. The resident was intubated and placed into the intensive care unit where he remains as of today, [DATE]. 3. The recorded the high temperature in Naples on [DATE] was 94 degrees Fahrenheit at 4:53 p.m. and a heat index of 100.8 degrees Fahrenheit with no precipitation. (source: Weather Underground website at http://www.wunderground.com/history/airport/KAPF/[DATE]/DailyHistory.html?req_c) 4. During an interview on [DATE] at 10:32 a.m., the facility Medical Director said he would prefer to limit the time residents are outside. He said in order to prevent this from happening again, the residents need to be supervised. He said having water outside would not have made a difference for Resident #1. He said all the talk is about dehydration, but the Resident's problem was his temperature. 5. During an interview on [DATE] at 1:18 p.m., the facility Administrator and the Director of Nursing (DON) said the outdoor video camera showed the resident entering the courtyard area at 1:52 p.m. He was in the shaded area for 2 minutes, then

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F 0271 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) propelled himself out of the shade and into the direct sun. The video showed the Social Worker interviewing the resident at 2:53 p.m. The resident was outside until 4:57 p.m. The video camera shows the resident shifting himself around in the wheelchair. The DON said on the video you can only see the back side of the chair and a silhouette of the resident (photographic evidence presented is in the file). During an interview on [DATE] at 11:35 a.m., the Social Worker said she asked the resident questions. He was able to tell her the year, month and date and was able to repeat 2 of the 3 items she asked him to repeat. She then asked him some mood questions and he was able to answer them appropriately. She said he was sitting a little bit beyond the cover and his body was in the sun. Her conversation with the resident was on video at 2:53 p.m. During an interview on [DATE] at 11:41 a.m., Staff I said, At lunch time, probably around 10 minutes to 2, the resident was trying to propel himself through the dining room where other residents were eating. He was not able to get outside at this point and I heard someone tell him he needed to go back out in the hall so they could bring the other residents out of the dining room (photographic evidence presented is in the file). The next time I saw him, I was sitting at the nurses station, and (Staff A) was charting in the back room. She asked me if 'he was outside' and was it raining. Staff I said, I got up to look out and saw (Resident #1) sitting outside. I told (Staff A), 'Yes, he is there and it is not raining.' This may have been around 4 p.m., I am not sure. Staff I continued, (Staff J), the ,[DATE] charge nurse (came in late around 4 p.m.) went into the assisted dining room around 4:30. I followed her into the dining room . I do not remember the whole conversation, but she mentioned 'him' and I said, 'I am going to bring him in.' He appeared to be sleeping. I went to put his feet on his foot rest, and when I did I saw he had mucous coming from his nose and drool from his mouth. I put his feet up on the pedals so I could bring him inside and noticed he was not responding. He was breathing slightly labored and I went to get a pulse oximeter to check his oxygen, and it was 92%. (Staff J) touched his skin and said he felt hot. I took him down the hall and other staff came into the room. We put him into the bed. Staff began wetting towels to put under his arms, groins and behind his neck, and his temperature was 105. I think it was taken under his arm. Another nurse and I then took his shirt off, and at that point everyone kept changing the cloths to try and cool him down. We also elevated his feet because his blood pressure was low. He was then transported to the hospital. During an interview on [DATE] at 12:04 p.m., Staff A said, I was the nurse assigned to the resident on [DATE]. I gave him his meds around 8:30 a.m., then tried to encourage him to eat a little more breakfast. Since he started on the [MEDICATION NAME] (an antidepressant medication) for the 'picking disorder' he has been sleeping a little more. I was told by the nurse practitioner that is was probably due to the [MEDICATION NAME]. He came down to my cart around a quarter to 12 and just sat there and waited by my cart. I took him to the main dining room around 12:15 p.m. and gave him 2 glasses of orange juice, soup and a cup of coffee. I went to lunch around 1:05 p.m. and came back around 1:35 p.m. and sat and charted for about 20 minutes. I saw him sitting outside of the door in the courtyard between 2 and 2:30 p.m. He was upright. I gave report to (Staff D), the evening nurse, around 3:10 or 3:15 p.m. and told her (Resident #1) was outside. I continued to chart and for some reason (I heard what sounded like thunder) I thought about Resident #1 and made the statement to (Staff I), '(Resident #1), isn't still setting outside is he?' Staff I went to check on him. He was hot, they brought him in, and he was not responsive. Staff A said, I was told by the assisted living facility that he liked to spend several hours a day in the sun. He has a history of wanting to be outside and once he was outside he did not want to come back in. Most of the other residents who go outside to the courtyard have family or a caregiver with them. 6. During an interview on [DATE] at 9:44 a.m., the DON said the facility staff was aware the resident liked to go outside. The staff was aware the resident would self-propel his wheelchair to sit in the sun. She said he was able to make his wants and needs known and would often yell for assistance. She said when the wife was called about his condition on [DATE] she commented, I bet he was out in the sun wasn't he? The DON said before this incident there was no process in place for monitoring and supervising residents in the courtyard. She said an outdoor protocol (for temperature >85 degrees Fahrenheit) has been established since the incident. She said it was developed with the assistance of Medical Director. The staff have also been in-serviced on rounding on the residents at the change of shift and every 2 hours. 7. The skilled nursing facility is co-located with an assisted living facility (ALF). Resident #1 was admitted to the ALF on [DATE]. The staff there found the resident wanted to remain outside on their patio much of the time. In an interview on [DATE] at 2:40 p.m., an ALF Certified Nursing Assistant said they obtained sun screen from the resident's spouse for the resident to use daily. Upon rising the staff would apply the sun screen. The resident would put on his sunglasses and his hat and go outside. They assigned the activity person to go out and give the resident fluids every ,[DATE] minutes. They brought the resident inside the facility at various times throughout the day. The ALF Activity Person's responsibility was to check on the resident frequently. She brought Resident #1 ginger ale and snacks to ensure he would drink and eat. They had gotten Resident #1 a cup holder for his wheelchair so he would have a drink available at all times. In an interview on [DATE] at 3 p.m., ALF Registered Nurse Staff H said the resident had no concept of whether he was sitting in the sun or in the shade; he could not tell the difference. These interventions were not put in place when Resident #1 was transferred to the SNF on [DATE]. During an interview on [DATE] at 9:44 a.m., the DON confirmed the SNF had no policy to address care of the residents when outdoors in hot weather. .
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview and record review the facility failed to ensure Resident #1 (1 of 8 records reviewed) was adequately supervised and monitored as he sat in 90+ degree Fahrenheit weather in the direct sunlight for approximately 3 hours. This resulted in the resident's internal body temperature overheating, and the resident becoming unresponsive. The resident was transported to the hospital. He remained on life support at the time of the survey. Subsequently, Resident #1 expired a week later. This failure created a situation that resulted in serious injury and harm to Resident #1, and requires immediate corrective action on the part of the facility. The Immediate Jeopardy beginning on [DATE] was identified on [DATE]. Substandard Quality of Care was identified at F323. The Immediate Jeopardy was abated on [DATE], based upon the implementation of corrective action. The corrective actions reduced the scope and severity to D. Four (Residents #1, #2, #6, and #7) of the 8 sampled residents were identified as going outside without supervision. The facility's census was 57 at the time of the survey. All residents who utilize the courtyard were at risk for such illness/injury and even death. The findings included: Elderly people (that is, people aged [AGE] years and older) are more prone to heat stress than younger people for several reasons: Elderly people do not adjust as well as young people to sudden changes in temperature. They are more likely to have a chronic medical condition that changes normal body responses to heat. They are more likely to take prescription medicines that impair the body's ability to regulate its temperature or that inhibit perspiration. (source: Extreme Heat by Centers for Disease Control at <http://stacks.cdc.gov/view/cdc/ >) 1. Resident #1 was a [AGE] year old male who had been residing in the assisted living facility (ALF) attached to the skilled nursing facility (SNF). Review of records showed his [DIAGNOSES REDACTED]. Recently he had lower extremity edema (swelling due to excess fluid, a sign of heart failure) and was on Lasix (a water pill) 40 milligrams twice a day. He was alert and oriented and able to make his needs known. The medical progress note dated [DATE] documented, Resident was seen yesterday as he transferred to SNF from ALF d/t (due to) his increased debility and exit seeking from ALF. Presently up in his W/C (wheel chair) and he does self-propel in his W/C and he does like to sit outside in the sun but needs to be monitored. The Nurse Practitioner failed to write orders for monitoring the resident while outside in the sun. 2. Nursing note dated [DATE] at 4:46 p.m. documented, Patient (Pt) wanting to go outside. CN (charge nurse) showed Pt that there was thunder and lightning outside. Nurse tried to discourage Pt from going out. Pt very HOH (hard of hearing), deaf and did not hear nurse. Pt continued outside in the storm. Nursing note dated [DATE] at 7:28 p.m. documented, Pt was found outside by day CN and evening CN in his WC, unresponsive. Pt was not arousable, placed in his bed and vital signs taken. Temperature was 105. 911 was called while other nurses tried to cool Pt down with cold towels until EMS (emergency medical services) arrived. Pt taken to (name of hospital). Spouse notified and Dr. (doctor) notified. Upon transfer to the hospital on [DATE] at 5 p.m., the resident's vital signs were: temperature 105 degrees Fahrenheit (very high), blood pressure ,[DATE] (low), pulse 126 (high), and respirations 40 (high). Review of the emergency room care note dated [DATE] at 5:50 p.m. showed, patient is a [AGE] year old male presenting to the ED (emergency department) due to hyperthermia. EMS was called today after the patient was left outside for too long. EMS reports that the patient was left outside on his wheelchair for approximately two hours. Upon arrival his oral temperature was 102 and rectal 107. History is limited due to patient's clinical state. emergency room care note at 8:07 p.m. documents the resident went into cardiac arrest, and CPR (cardiopulmonary resuscitation) was

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NAME OF PROVIDER OF SUPPLIER **ARISTOCRAT, THE**		STREET ADDRESS, CITY, STATE, ZIP **10949 PARNU STREET NAPLES, FL 34109**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) performed. The resident was intubated and placed into the intensive care unit where he remains as of today, [DATE]. 3. The recorded the temperature in Naples on [DATE] was 93.9 degrees Fahrenheit at 3:53 p.m. and heat index of 100.8 degrees Fahrenheit with no precipitation. (source: Weather Underground website at http://www.wunderground.com/history/airport/KAPF/[DATE]/DailyHistory.html?req_c) 4. During an interview on [DATE] at 10:32 a.m., the facility Medical Director said he would prefer to limit the time residents are outside. He said in order to prevent this from happening again, the residents need to be supervised. He said having water outside would not have made a difference for Resident #1. He said all the talk is about dehydration, but the Resident's problem was his temperature. 5. During an interview on [DATE] at 1:18 p.m., the facility Administrator and the Director of Nursing (DON) said the outdoor video camera showed the resident entering the courtyard area at 1:52 p.m. He was in the shaded area for 2 minutes, then propelled himself out of the shade and into the direct sun. The video showed the Social Worker interviewing the resident at 2:53 p.m. The resident was outside until 4:57 p.m. The video camera shows the resident shifting himself around in the wheelchair. The DON said on the video you can only see the back side of the chair and a silhouette of the resident (photographic evidence presented is in the file). During an interview on [DATE] at 11:35 a.m., the Social Worker said she asked the resident questions. He was able to tell her the year, month and date and was able to repeat 2 of the 3 items she asked him to repeat. She then asked him some mood questions and he was able to answer them appropriately. She said he was sitting a little bit beyond the cover and his body was in the sun. Her conversation with the resident was on video at 2:53 p.m. During an interview on [DATE] at 11:41 a.m., Staff I said, At lunch time, probably around 10 minutes to 2, the resident was trying to propel himself through the dining room where other residents were eating. He was not able to get outside at this point and I heard someone tell him he needed to go back out in the hall so they could bring the other residents out of the dining room (photographic evidence presented is in the file). The next time I saw him, I was sitting at the nurses station, and (Staff A) was charting in the back room. She asked me if 'he was outside' and was it raining. She said, I got up to look out and saw (Resident #1) sitting outside. I told (Staff A), 'Yes, he is there and it is not raining.' This may have been around 4 p.m., I am not sure. Staff I continued, (Staff J), the ,[DATE] charge nurse (came in late around 4 p.m.) went into the assisted dining room around 4:30. I followed her into the dining room . I do not remember the whole conversation, but she mentioned 'him' and I said, 'I am going to bring him in.' He appeared to be sleeping. I went to put his feet on his foot rest, and when I did I saw he had mucous coming from his nose and drool from his mouth. I put his feet up on the pedals so I could bring him inside and noticed he was not responding. He was breathing slightly labored and I went to get a pulse oximeter to check his oxygen, and it was 92%. (Staff J) touched his skin and said he felt hot. I took him down the hall and other staff came into the room. We put him into the bed. Staff began wetting towels to put under his arms, groins and behind his neck, and his temperature was 105. I think it was taken under his arm. Another nurse and I then took his shirt off, and at that point everyone kept changing the cloths to try and cool him down. We also elevated his feet because his blood pressure was low. He was then transported to the hospital. She said before this incident, the facility did not have a protocol in place to supervise residents in the courtyard or a hot weather protocol. During an interview on [DATE] at 12:04 p.m., Staff A said, I was the nurse assigned to the resident on [DATE]. I gave him his meds around 8:30 a.m., then tried to encourage him to eat a little more breakfast. Since he started on the Zoloft (an antidepressant medication) for the 'picking disorder' he has been sleeping a little more. I was told by the nurse practitioner that is was probably due to the Zoloft. He came down to my cart around a quarter to 12 and just sat there and waited by my cart. I took him to the main dining room around 12:15 p.m. and gave him 2 glasses of orange juice, soup and a cup of coffee. I went to lunch around 1:05 p.m. and came back around 1:35 p.m. and sat and charted for about 20 minutes. I saw him sitting outside of the door in the courtyard between 2 and 2:30 p.m. He was upright. I gave report to (Staff D), the evening nurse, around 3:10 or 3:15 p.m. and told her (Resident #1) was outside. I continued to chart and for some reason (I heard what sounded like thunder) I thought about Resident #1 and made the statement to (Staff I), '(Resident #1), isn't still setting outside is he?' Staff I went to check on him. He was hot, they brought him in, and he was not responsive. Staff A said, I was told by the assisted living facility that he liked to spend several hours a day in the sun. He has a history of wanting to be outside and once he was outside he did not want to come back in. Most of the other residents who go outside to the courtyard have family or a caregiver with them. 6. During an interview on [DATE] at 9:44 a.m., the DON said the facility staff was aware the resident liked to go outside. The staff was aware the resident would self-propel his wheelchair to sit in the sun. She said he was able to make his wants and needs known and would often yell for assistance. She said when the wife was called about his condition on [DATE] she commented, I bet he was out in the sun wasn't he? The DON said before this incident there was no process in place for monitoring and supervising residents in the courtyard. She said an outdoor protocol (for temperature >85 degrees Fahrenheit) has been established since the incident. She said it was developed with the assistance of Medical Director. The staff have also been in-serviced on rounding on the residents at the change of shift and every 2 hours. 7. During interviews, Residents #2, #3, #4, #6, #7, and #8 indicated the facility did not provide drinks, sun protection, or supervision when residents are outside in the hot weather. 8. In an interview on [DATE] at 3:05 p.m., Resident #2 stated, I go outside when they take me, not for very long, too hot. 10 or 15 minutes, that's all. 9. In an interview on [DATE] at 4:30 p.m., Resident #3 stated, I never go outside unless my family is with me; we just take a walk or something, and my daughter brings me drinks. I don't know if they would check on me; I don't go out. 10. In an interview on [DATE] at 2:52 p.m., Resident #4's spouse stated, We always sit in front of the building where we can be seen from the front desk. We don't go outside in this weather it's too hot. Resident #4 said she never goes outside alone. We go out when it is cooler. No one ever comes out and offers us water or lotion, but we don't usually stay out that long, maybe 15 minutes or so. I see people walking in and out of the building, but I don't think they are checking on us. 11. In an interview on [DATE], at 2:36 p.m., Resident #6 said she frequently goes outside to sit in the sun. I usually sit by the door so they can see me. No they never give us water outside; they give us water in our room. No, they never offer suntan lotion or a hat. I never see anyone come outside to check on me. 12. In an interview on [DATE] at 2:58 p.m., Resident #7 stated, Yes, I like to go outside, but I didn't go outside today. No, they never bring us drinks or ask if we want one when we go outside. We get that in here. No, they don't check on me when I go outside, but I usually go outside with a friend (another resident in the facility). I usually stay outside for about 30 minutes or so. 13. In an interview on [DATE] at 4:45 p.m., Resident #8 stated, I don't speak good English, just a little bit. I go out; too hot now. Don't know if they check, no drinks. 14. The skilled nursing facility is co-located with an assisted living facility (ALF). Resident #1 was admitted to the ALF on [DATE]. The staff there found the resident wanted to remain outside on their patio much of the time. In an interview on [DATE] at 2:40 p.m. an ALF Certified Nursing Assistant said they obtained sun screen from the resident's spouse for the resident to use daily. Upon rising the staff would apply the sun screen. The resident would put on his sunglasses and his hat and go outside. They assigned the activity person to go out and give the resident fluids every ,[DATE] minutes. They brought the resident inside the facility at various times throughout the day. The ALF Activity Person's responsibility was to check on the resident frequently. She brought Resident #1 ginger ale and snacks to ensure he would drink and eat. They had gotten Resident #1 a cup holder for his wheelchair so he would have a drink available at all times. In an interview on [DATE] at 3:00 p.m., ALF Registered Nurse Staff H said the resident had no concept of whether he was sitting in the sun or in the shade; he could not tell the difference. The SNF had no policy to address care of the residents when outdoors in hot weather which was confirmed in an interview with the DON on [DATE] at 9:44 a.m. 15. These systems failures created a hazardous situation resulting in critical harm for Resident #1 on [DATE]. The facility began to put corrective actions in place after the resident was harmed. The Immediate Jeopardy was abated on [DATE] based upon the following corrective actions put into place by the facility: -Adopted policy entitled Resident Safety: Outdoor Monitoring Guidelines, -Installed a doorbell that rings upon exiting and entering the courtyard, -Placed a water cooler with cups in the courtyard, and -Assigned staff to monitor the courtyard area every 20 minutes. .
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and interview, the facility leadership failed to ensure residents utilizing the outdoor area of the courtyard are supervised. The system failure began with the Nurse Practitioner's acknowledgement the resident's for monitored for time in the sun. The Administrator and the Director of Nursing failed to ensure the staff knew to supervise and monitor residents who utilize the courtyard. The facility failed to establish a hot weather protocol to protect all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **105790**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **08/29/2014**

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) residents from the extreme heat and humidity in South Florida. Facility leadership failed to address this system-wide failure leading to one (Resident #1) being left on the courtyard in the sun resulting in serious harm. He remained on life support at the time of the survey. Subsequently, Resident #1 expired a week later. This failure created a situation that resulted in serious injury and harm to Resident #1, and requires immediate corrective action on the part of the facility. The Immediate Jeopardy beginning on [DATE] was identified on [DATE]. The Immediate Jeopardy was abated on [DATE], based upon the implementation of corrective action. Four (Residents #1, #2, #6, and #7) of the 8 sampled residents were identified as going outside without supervision. The facility's census was 57 at the time of the survey. All residents who utilize the courtyard were at risk for such illness/injury and even death. The findings included: Elderly people (that is, people aged [AGE] years and older) are more prone to heat stress than younger people for several reasons: Elderly people do not adjust as well as young people to sudden changes in temperature. They are more likely to have a chronic medical condition that changes normal body responses to heat. They are more likely to take prescription medicines that impair the body's ability to regulate its temperature or that inhibit perspiration. (source: Extreme Heat by Centers for Disease Control at <http://stacks.cdc.gov/view/cdc/ >) 1. A copy of the administrator's job description signed by the Administrator [DATE] was provided by the facility. The Administrative Responsibilities section notes The administrator is specifically responsible for the following functions: Patients Accept patients for admission.Maintain and implement programs of patient education and rehabilitation for the promotion of mental and physical health. Medical Staff Work with medical staff,. responsible for rendering professional and medical service to provide the best possible care to all patients. 2. Review of the medical progress note dated [DATE] documented Resident was seen yesterday as he transferred to SNF (skilled nursing facility) from ALF (assisted living facility) d/t (due to) his increased debility and exit seeking from ALF. Presently up in his W/C (wheel chair) and he does self-propel in his W/C and he does like to sit outside in the sun but needs to be monitored. The Nurse Practitioner failed to include a plan to monitor the resident while in the sun in the orders. 3. The recorded the temperature in Naples on [DATE] was 93.9 degrees Fahrenheit at 3:53 p.m. and heat index of 100.8 degrees Fahrenheit with no precipitation. (source: Weather Underground website at http://www.wunderground.com/history/airport/KAPF/[DATE]/DailyHistory.html?req_c) 4. During an interview on [DATE] at 1:18 p.m., the facility Administrator and the Director of Nursing (DON) said the outdoor video camera showed the resident entering the courtyard area at 1:52 p.m. He was in the shaded area for 2 minutes then propelled himself out of the shade and into the direct sun. The video showed the Social Worker interviewing the resident at 2:53 p.m. The video showed the resident remained outside until 4:57 p.m. During an interview on [DATE] around 3:00 p.m., the DON said Staff C assisted the resident outside to the courtyard on [DATE] at 1:52 p.m. The DON said because he did not offer Resident #1 fluids before he assisted the resident outside, Staff C was terminated. During an interview on [DATE] around 3:00 p.m., the DON said Staff D was the 3 p.m.-11 p.m. nurse assigned to Resident #1 on [DATE]. The DON said because she did not make rounds or find Resident #1, Staff D was terminated. During an interview on [DATE] around 3:00 p.m., the DON said Staff E was the 3 p.m. -11 p.m. aide assigned to Resident #1 on [DATE]. The DON said because she knew Resident #1 was outside in the courtyard and did not go and get him, Staff E was terminated. 5. During interviews on [DATE], Residents #2, #3, #4, #6, #7, and #8 indicated the facility did not provide drinks, sun protection, or supervision when residents are outside in the hot weather. Residents #2, #6, and #7 indicated they go outside without supervision. (refer to F323 for detailed interviews) 6. During an interview on [DATE] around 9:44 a.m., the DON admitted , before the incident with Resident #1, there was no process in place for monitoring and supervising residents in the courtyard. She said an outdoor protocol (for temperatures >85 degrees Fahrenheit) was established after the incident. She said it was developed with the assistance of the Medical Director. The staff have also been in-serviced on rounding on the residents at the change of shift and every 2 hours. 7. These systems failures created a situation resulting in critical harm for Resident #1 on [DATE]. The facility began to put corrective actions in place after the resident was harmed. The Immediate Jeopardy was abated on [DATE] based upon the following corrective actions put into place by the facility: -Adopted policy entitled Resident Safety: Outdoor Monitoring Guidelines, -Installed a doorbell that rings upon exiting and entering the courtyard, -Placed a water cooler with cups in the courtyard, and -Assigned staff to monitor the courtyard area every 20 minutes.