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
	AL11953272	A. BUILDING: _____ B. WING _____	09/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD RETIREMENT CENTER	1220 JIMMY ANN DRIVE DAYTONA BEACH, FL 32117

(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 investigation (complaint investigation #2019006690) was conducted at Lakewood Retirement Center Assisted Living Facility on . The facility had deficiencies at the time of the survey.	A 000		
A 165	429.23(&) FS; 58A-5.0241 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 ; 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	A 165		

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A 165	Continued From page 1 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, by electronic mail, facsimile, or United States 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, by electronic mail, facsimile, or United States 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) [illegible], neglect, or [illegible] 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 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	A 165		

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A 165	Continued From page 2 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 Department of Elderly Affairs may adopt rules necessary to administer this section. 58A-5.0241 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 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 clinical record review, observation and staff interview the facility failed to file a 15-day report to the Agency for Health Care Administration following an adverse incident involving one resident (Resident #1) out of three sampled residents.	A 165		

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A 165	Continued From page 3 The findings include: Review of Resident #1's clinical record progress notes revealed a resident observation note dated [illegible] that read: Resident seen by [Resident #1's physician] today for routine visit. Resident stable at this time. No medication changes. Next visit scheduled for [illegible]. A second note dated [illegible] read: Late Entry. Resident was being pushed by caregiver and [illegible] out of chair [illegible] forward, hit her [illegible] and was sent to ER (Emergency Room). Physician notified, family notified (Photographic evidence obtained). Review of the hospital record for Resident #1 dated [illegible] at 18:16 hours revealed it read: Discharge plan. You have a [illegible]. This is also called a [illegible]. There is [illegible] and some [illegible] under the skin. This injury generally takes a few days to a few weeks to heal. During that time, the [illegible] will typically change in color from reddish, to purple-blue, to greenish-yellow, then to yellow-brown. Follow up with your physician. Reason for visit: [illegible]. Initiate precautions. Computed [illegible] (CT) [illegible] without contrast completed (Photographic evidence obtained). Resident #1 was observed on [illegible] at 11:55 am. She was seated at a table in the dining room, in a dining room chair at a table for four. She was dressed in slacks, a blouse, sweater, shoes and socks. She made [illegible] contact with this surveyor, Employee A, the assistant to the administrator, and the administrator. She did not react to Employee A's greeting. Employee A explained that Resident #1 speaks Spanish only and has [illegible]. She has no behaviors. She is [illegible] most of the time. The resident appeared to be in no distress. There were no	A 165		

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A 165	Continued From page 4 noticeable . . . . . or signs of injury. During an Interview with administrator and Employee A at 12:46pm, the administrator stated she did not think she had filed a 15-day report for the incident that occurred on . She indicated she did not know she needed to do so. Adverse incident reporting was reviewed with the administrator and Employee A. They both expressed understanding. The administrator stated she interviewed the caregiver, Employee B, at the time of the incident with Resident #1. Employee B told her that she was taking Resident #1 to the restroom. She started to push the wheelchair from behind. Employee B told the administrator "She just out of the chair". The administrator stated she was not sure that Employee B knew that the resident had put her . . . down. The administrator stated there was no written documentation of the investigation. Employee B was re in-serviced and then she was let go about a week later. The administrator stated that Employee B had several jobs and was "over confident". She did not take the time to explain to the resident what was about to happen and tell the resident anything prior to attempting to move her. Review of the staff in-service sign-in sheet entitled Wheelchair Bound Residents dated . . . . . revealed Employee B had signed in acknowledgment of receiving the training (Photographic evidence obtained). Review of the staff schedules revealed Employee B was last on the schedule on . . . . . . Class III	A 165		