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 |
|---|---|---|---|
| | AL11911858 | A. BUILDING: _____ B. WING _____ | 11/02/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TROPICAL GARDEN VILLAS INC. (A | 428 SOUTH 'F' STREET LAKE WORTH, FL 33460 |

| (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<br><br>An unannounced licensure Complaint, #2020017593, Focused Control and Generator Assessment Monitoring Survey was conducted on and at Tropical Garden Villas Inc. The Complaint allegations were substantiated. The facility had deficiencies at the time of the survey. | A 000 | | |
| A 010 SS=D | 429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency<br><br>429.26<br>(1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility:<br>(a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.<br>(b) A facility may admit or retain a resident who requires the use of assistive devices.<br>(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, | A 010 | | |

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 |
|---|---|---|---|
| | AL11911858 | A. BUILDING: _____ B. WING _____ | 11/02/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TROPICAL GARDEN VILLAS INC. (A | 428 SOUTH 'F' STREET LAKE WORTH, FL 33460 |

| (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 010 | Continued From page 1<br>additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.<br>(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:<br>a. Move, turn, or reposition without total physical assistance;<br>b. Transfer to a chair or wheelchair without total physical assistance; or<br>c. Sit safely in a chair or wheelchair without personal assistance or a physical .<br>2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.<br>3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.<br>(2). A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. | A 010 | | |

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 |
|---|---|---|---|
| | AL11911858 | A. BUILDING: _____ B. WING _____ | 11/02/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TROPICAL GARDEN VILLAS INC. (A | 428 SOUTH 'F' STREET LAKE WORTH, FL 33460 |

| (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 010 | Continued From page 2<br><br>(3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility.<br><br>59A-36.006<br>(4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are:<br>(a) The resident may be bedridden for no more than 7 consecutive days.<br>(b) A resident requiring care of a may be retained provided that:<br>1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider,<br>2. The condition is documented in the resident's record; and,<br>3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from | A 010 | | |

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 |
|---|---|---|---|
| | AL11911858 | A. BUILDING: _____ B. WING _____ | 11/02/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TROPICAL GARDEN VILLAS INC. (A | 428 SOUTH 'F' STREET LAKE WORTH, FL 33460 |

| (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 010 | Continued From page 3<br><br>the facility.<br>(c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:<br>1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;<br>2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency;<br>3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and,<br>4. Documentation of the requirements of this paragraph is maintained in the resident's file.<br>(d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times.<br>(e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.<br>(f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.<br>(g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview and record | A 010 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11911858 | A. BUILDING: _____ B. WING _____ | 11/02/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TROPICAL GARDEN VILLAS INC. (A | 428 SOUTH 'F' STREET LAKE WORTH, FL 33460 |

| (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 010 | Continued From page 4<br><br>review, the facility failed to determine the continued appropriateness for residence in the facility, for 1 out of 11 sampled residents (Resident #5) by not providing the resident's established needs and not ensuring that the resident received a medical examination documented on a Resident Health Assessment form to determine if the resident needed any additional care and services and if the resident met the criteria for continued residency.<br><br>The findings included:<br><br>In an interview with the facility Supervisor on [redacted] at 10:30am, she stated that the facility record titled "Incident Reporting" and its subsequent 4 pages which included questions and answers relating to the facility's resident incident practices were the facility's incident policies and procedures. She stated at this time that the additional "ALF incident report" sheet used to further describe an incident and a resident's condition was also part of the facility's resident incident policies and procedures. She stated that the facility did not have any resident [redacted] prevention policies and procedures. Photographic evidence is attached.<br><br>Review of the facility resident incident (undated) policies and procedures indicated that the facility must create a report for any resident who has [redacted], been injured and had a medical emergency. Review of this document indicated that the facility must also document how this resident incident happened, the resident's condition and implement an intervention to assist the resident.<br><br>In an interview with the Administrator on [redacted] at 10:25am, he stated that Resident #5 went to | A 010 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11911858 | A. BUILDING: _____ B. WING _____ | 11/02/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TROPICAL GARDEN VILLAS INC. (A | 428 SOUTH 'F' STREET LAKE WORTH, FL 33460 |

| (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 010 | Continued From page 5 | A 010 | | |

the hospital once in . . , . . . . . because the resident was weak and couldn't move, but he did not know when this actually happened. He stated that he didn't know what services the hospital provided to the resident or if the resident required additional needs after the resident returned to the facility. He stated that the facility did not review any of the hospital documentation that the resident provided to the facility after the resident returned from the hospital. He stated that the facility did not notify the resident's primary care physician of the resident going to the hospital and that the resident's hospice nurse was aware of this, but he didn't know if hospice assessed the resident or if the resident required additional care and services.

In an observation on at 10:51am, Resident #5 approached the facility office by walking independently and without supervision from his bedroom without a walker. At this time, the resident complained about his , and that he did not receive any of his medications that morning. During this observation, the resident's right . . . had a gauze bandage wrapped around it and the resident pointed to this as the source , . .

In an interview with the facility Supervisor on at 10:56am, she stated that Resident #5 did not receive his , . medications on . . . . . and because the resident refused all of his medications. She stated that the resident usually received his , medications twice daily, at 8am and 7pm.

In an interview with Resident #5 on . . . . . at 11:07am, he stated that he did not yet receive any of his , . medication for that day and he gestured that he was still in , .

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11911858 | A. BUILDING: _____ B. WING _____ | 11/02/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TROPICAL GARDEN VILLAS INC. (A | 428 SOUTH 'F' STREET LAKE WORTH, FL 33460 |

| (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 010 | Continued From page 6<br><br>Review of Resident #5's health assessment dated on [redacted] indicated that the resident was diagnosed with left [redacted] and [redacted]. Review of this health assessment indicated that the resident needed hospice services, that the resident needed supervision with ambulation and with the use of a walker assistive device, and assistance with bathing and [redacted] to be performed by hospice staff. Further review of this health assessment indicated that the resident needed daily assistance with self administration of medications.<br><br>Review of resident #5's medication observation record dated from [redacted] to on [redacted] indicated that the resident received [redacted] 8mg tablets for [redacted] as needed every morning and afternoon with exception of [redacted] in the afternoon and [redacted] in the morning. Further review of this medication record indicated that the resident did not receive his [redacted] medication or the other 8 prescribed medications on [redacted] at 8:00am.<br><br>Review of resident #5's hospice record indicated that that he was admitted to receive hospice services in the facility on [redacted] for [redacted] end of life general needs. Review of the hospice plan of care dated from [redacted] to [redacted] indicated that the resident was dependent in 4 out of 6 activities of daily living, he developed a [redacted] on his left heel and the resident went to the hospital on [redacted] due to a [redacted] and left [redacted].<br><br>Review of the resident's hospital discharge record dated on [redacted] indicated that the resident | A 010 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11911858 | A. BUILDING: _____ B. WING _____ | 11/02/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TROPICAL GARDEN VILLAS INC. (A | 428 SOUTH 'F' STREET LAKE WORTH, FL 33460 |

| (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 010 | Continued From page 7<br><br>arrived to the hospital at 11:42am and the reason for this visit was for a . Further review of the discharge instructions indicated that the resident must be followed up by his physician due to his .<br><br>In an interview with the Administrator on at 11:10am, he stated that he was not aware that the resident had a , on his heel and that he knew the resident went to the hospital on but not on . He stated that he had been trying to have the resident move to another facility because the resident was too much to handle and was not compliant with his care. He stated that the facility had previously issued the resident two separate 45-day notices for relocation to another facility, but this did not happen and he relied on the hospice staff to find another facility for the resident to relocate.<br><br>In an interview with the Supervisor on at 11:45am, she stated that she just found out today that Resident #5 had gone to the hospital on as well, but she did not know the reason why. She stated that the facility did not create an incident report for the resident having gone to the hospital on and .<br><br>In an interview with the Administrator on at 11:50am, he stated that he was not aware of the dates in , when Resident #5 went to the hospital or the reasons why. He stated that the facility did not keep an incident log and that an incident report must be completed shall any resident have a or accident. He stated that the facility did not create an incident report for each time Resident #5 went to the hospital in , and the facility also did not document this on the resident's record. He stated that the facility did not arrange for the | A 010 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11911858 | A. BUILDING: _____ B. WING _____ | 11/02/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TROPICAL GARDEN VILLAS INC. (A | 428 SOUTH 'F' STREET LAKE WORTH, FL 33460 |

| (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 010 | Continued From page 8<br><br>resident to get an assessment from a physician to help the facility determine if the resident's continued residence in the facility was appropriate.<br><br>Further observations on at 12:50pm, Resident #5 was walking independently, without staff supervision and without using his walker. In an observation on at 12:55pm inside Resident #5's bedroom, Resident #5's walker was stored inside the closet behind luggage bags and other clutter. Photographic evidence obtained<br><br>In an interview with the supervisor on at 1:00pm, she stated that she retrieved Resident #5's walker from the deepest part of his closet so he may have access to it and use it as per the resident's health assessment.<br><br>In an interview with Resident #5's hospice nurse on at 10:35am, she stated that Resident #5 had been on hospice for about 1 year for his diagnosis of She stated that she usually saw the resident once weekly and the hospice aide saw him twice weekly to provide assistance with his bathing. She stated that the facility was responsible to provide the rest of the resident's activities of daily living care, including supervision with ambulation. She stated that the resident was transported to the hospital on 2 occasions in due to in the facility. She stated that the resident returned to the facility on the same day after his hospital visits and that the resident had unsteady gait which likely contributed to his She stated that she was not aware of what interventions the facility implemented after the resident's in so to reduce his accident risk. She stated that the resident's condition was considerably worse about 3 months | A 010 | | |

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 |
|---|---|---|---|
| | AL11911858 | A. BUILDING: _____ B. WING _____ | 11/02/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TROPICAL GARDEN VILLAS INC. (A | 428 SOUTH 'F' STREET LAKE WORTH, FL 33460 |

| (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 010 | Continued From page 9<br><br>ago and likely needed to go to a nursing home, and she felt that the resident had recently improved somewhat. She stated that since the resident was not compliant with many aspects of his own care, the resident may need a higher level of care. She stated that she was not aware what the facility arranged or was arranging to relocate the resident to another facility. She stated that the resident's , on his left heel was presently a healed .<br><br>In an interview with Resident #5 on at 11:49am, he stated that he went to the hospital by ambulance on because he did not feel good. He stated that he received an at the hospital and that the hospital staff told him that he did not require to be hospitalized and he returned to the facility the same day. He also stated that once he returned to the facility, no facility staff member asked him anything about his hospital visit or his updated condition.<br><br>Class III | A 010 | | |
| A 152 SS=D | 59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other<br><br>(3) OTHER REQUIREMENTS.<br>(a) All facilities must:<br>1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.;<br>2. Be maintained free of hazards; and,<br>3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good | A 152 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11911858 | A. BUILDING: _____ B. WING _____ | 11/02/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TROPICAL GARDEN VILLAS INC. (A | 428 SOUTH 'F' STREET LAKE WORTH, FL 33460 |

| (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 152 | Continued From page 10<br><br>working order.<br>(b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings:<br>1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [illegible] to ensure easy access by the resident,<br>2. A closet or wardrobe space for hanging clothes,<br>3. A dresser, [illegible] or other furniture designed for storage of clothing or personal effects,<br>4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and,<br>5. A comfortable chair, if requested.<br>(c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency.<br>(d) Residents who use portable bedside commodes must be provided with privacy during use.<br>(e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be [illegible].<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview and record review the facility failed to ensure the safety of one (2) of (11) residents sampled by ensuring a safe environment that is free from pest, bedbugs/or other hazards.<br><br>The findings include:<br><br>During a confidential resident interview conducted | A 152 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11911858 | A. BUILDING: _____ B. WING _____ | 11/02/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TROPICAL GARDEN VILLAS INC. (A | 428 SOUTH 'F' STREET LAKE WORTH, FL 33460 |

| (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 152 | Continued From page 11<br><br>on . . . . . at 9:41 AM, the resident stated that he/she has seen bugs in his room, but that they (facility) sprayed and he haven't seen them anymore.<br><br>During interview with the Administrator and Supervisor on . . . . . at 11:00 AM in the main office, this Surveyor observed a roach crawling toward the . . . of Resident #5 who was speaking with the Administrator, and another roach crawling on the door frame. The Administrator observed the roaches but took no actions.<br><br>On . . . . . at 11:51 AM, during a confidential resident interview , he/she stated he has seen bugs "running all around the place. The facility sprays, but it doesn't do any good." This Surveyor asked if he had been bitten by the bugs and he stated he did not remember being bitten.<br><br>On at 9:32 AM, this Surveyor interviewed the Administrator and Supervisor to discuss the living environment. The Administrator stated Resident #5 eats in his room, which may be the cause for the roaches being in his room. "We try to encourage them not to, but he does. So, we saw excessive activity in (Resident #5's) room. He also stated the pest control company came in and treated.<br><br>On at 10:29 the Administrator stated during interview that they had a new resident (Resident #9) who moved in a few months ago. This Surveyor observed his move in dated as . He stated they never had the problem with bedbugs until he came. He stated that Resident #9 would go out of the facility with his mom, sign-out and go downtown. "So, we don't know if he brought them in." He stated Resident | A 152 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11911858 | A. BUILDING: _____ B. WING _____ | 11/02/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TROPICAL GARDEN VILLAS INC. (A | 428 SOUTH 'F' STREET LAKE WORTH, FL 33460 |

| (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 | Continued From page 12<br><br>#9 left the facility on Friday . . . . . to move in with his mom. This Surveyor observed on . . . . . resident #9's personal items packed up and the bed stripped of its bedding.<br><br>During interview with the Administrator on . . . . . at 11:01 AM, the Administrator provided this Surveyor a copy of 2 work orders from (Pest Control Company) as follows:<br><br>. . . . . verifying treatment for bed bugs - Spray, Vacuum and follow up on .<br>. . . . . verifying treatment for bed bugs: Vacuum, spray, follow up on .<br><br>This Surveyor interviewed the Administrator and requested information documenting the recent pest control visits. The Administrator provided this Surveyor a copy of the recent pest control treatment from (Pest Control) company. The following was noted.<br><br>a) . . . . . : Job Description: Pest control service treated inside and outside for pest control. Refill bait stations outside for rodent control.<br>b) : Job Description: Pest control service treated inside and outside for pest control. Refilled bait stations outside for rodents control.<br>c) . . . . . : Job Description: Pest control service treated inside and outside for pest control. Refilled bait stations outside for rodents control.<br><br>Relative to Bedbugs, the Administrator stated during the interview on at 11:10 AM, that they found bedbugs a few weeks ago when they were cleaning Resident #5s room. He stated they were stripping the beds and saw them. He also stated they change the sheets at least once a week. He further stated that if residents have an accident, they change them more often. He | A 152 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11911858 | A. BUILDING: _____ B. WING _____ | 11/02/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TROPICAL GARDEN VILLAS INC. (A | 428 SOUTH 'F' STREET LAKE WORTH, FL 33460 |

| (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 152 | Continued From page 13<br><br>stated that (Pest Control Company) came in and treated for them. Stated they stripped the beds and changed them after the treatment. He stated the (Pest Control Company) came 2 weeks later to finish the treatments.<br><br>The Supervisor further stated they asked Resident #5 if he had been bitten and he said no. She stated there has been no other sighting of bedbugs, except in his room. She also stated that they have not seen any more since the treatment. Relative to Resident #5 condition on , she stated she was not there the day Resident #5 went to the hospital.<br><br>On at 11:51 AM , this Surveyor conducted an interview with Resident #5 who stated there are "roaches running all around" and that they spray. Also stated he had bedbugs. This surveyor asked if he had reported it to management. He stated he had. This Surveyor asked the resident again if he experienced being bitten by bedbugs. He stated he did not remember being bitten.<br><br>This Surveyor reviewed the resident #5 file again on at 12:04 PM to determine if any documentation reporting bugs/or bedbugs was in the file. Observation revealed the same single facility Resident Observation Log form with entries, no documentation could be located. Review of Resident's file revealed no entries related to bedbugs or roaches were observed in the resident's file. And no additional documentation was provided this Surveyor.<br><br>On at 1:29 PM, the Survey Team met with the Administrator to conduct the Exit Interview. He was advised of the findings; failure to provide a safe living environment free of bugs | A 152 | | |

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 |
|---|---|---|---|
| | AL11911858 | A. BUILDING: _____ B. WING _____ | 11/02/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TROPICAL GARDEN VILLAS INC. (A | 428 SOUTH 'F' STREET LAKE WORTH, FL 33460 |

| (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 152 | Continued From page 14<br>and pest. The Administrator acknowledged the findings as stated he would be working to correct the issues related to them.<br><br>Class III | A 152 | | |