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
	AL11910916	A. BUILDING: _____ B. WING _____	R 03/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPWORTH VILLAGE RETIREMENT COM	5300 West 16 Avenue HIALEAH, FL 33012

(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 revisit to a Complaint investigation (2020003782) was conducted at Epworth Village Retirement Community on to . A deficiencies was identified at the time of the survey.	{A 000}		
{A 025} SS=F	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	{A 025}		

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{A 025}	Continued From page 1 resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide care and supervision appropriate to the needs of two of sampled 39 sampled residents to prevent resident resulting in injuries (Resident #11, #12). Findings include: 1) A review of the facility ' s incident report log dated showed at 9:15 AM, dietary staff found Resident #11 lying on the floor, on his near the of his recliner. The staff noted that the resident had a scratch on the left lower side of his .	{A 025}		

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{A 025}	Continued From page 2 A review of a second facility incident report log dated showed at 9:45 AM, nursing staff were notified that Resident #11 was on the floor near the piano near the main dining area. When asked by Staff O where his walker was, Resident #11 stated, "It ' s up in my apartment." Staff noted that the resident had no injuries. On at 2:48 PM, when asked about the on , Staff O stated, "[Resident #11] has so many times I would have to read my notes to refresh my memory." A review of a third facility incident report dated showed at 7:30 PM, Resident #11 was found on the bathroom floor of his apartment. A was noted on the upper right portion of the resident ' s . A review of Resident #11's health assessment dated showed medical diagnoses and a history of , 's, Major , frequent , and physical decline. The resident needed supervision with eating and toileting and assistance with ambulation, bathing, , self-care, and transferring. The health assessment also indicated that Resident #11 had precautions. There was no documentation of the precautions which had been in place at the time of the three resident . 2) A review of the facility ' s incident log dated showed at 12:27 PM, Resident #12 was found on the floor of her apartment on her . The resident complained of discomfort on her .	{A 025}		

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{A 025}	Continued From page 3 A review of a second facility incident log dated ... showed at 11 AM, Resident #12 was found on the bathroom floor near the shower. The resident was noted to be ... on the left ... A review of a third facility incident log dated ... showed at 11:40 PM, Resident #12 was found lying on her ... on her bedroom floor. No apparent injuries were noted. A review of Resident #12's health assessment dated ... showed medical diagnoses and a history of left ... replacement, ... and ... The resident needed supervision with ambulation, transferring and needed assistance with bathing and ... The health assessment also indicated that Resident #12 had ... precautions. There was no documentation of the ... precautions which had been in place at the time of the three resident ... Class III	{A 025}		