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
	AL11965634	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF CARROLLWOOD	2626 WEST BEARSS AVENUE CARROLLWOOD, FL 33618

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A 000	Initial Comments Assisted Living Facility Two complaint surveys, CCR# 2012006033 & CCR# 2012008656, were conducted on ..... The Elmcroft at Carrollwood Assisted Living Facility had deficiencies found at the time of the visit. The following deficiencies were cited relative to CCR# 2012008656: A 0025, A 0030, and A 0076. No deficiencies were cited relative to CCR# 2012006033.	A 000		
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, 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 individual. (c) 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; contacting the	A 025		

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A 025	Continued From page 1	A 025		

resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.
(e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which 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 ensure that it provided appropriate supervision for 1 (#1) of 3 sampled residents in regards to A) contacting the resident ' s physician to communicate a significant event of the resident being found between the mattress and the side rail and a [illegible] event, B) Failed to ensure that an event involving Resident #1 becoming entrapped between a mattress and a ½ side rail was reviewed and analyzed to prevent future occurrences of the same type of event. Failing to communicate to the physician significant events and failing to take proactive measures to eliminate hazardous entrapment equipment can place a resident at risk for harm and injury.

Findings include:

A record review of Resident #1's clinical chart on [illegible] revealed that the resident was admitted to the facility in [illegible] 2011. A further review of the chart revealed a Health Assessment, 1823, dated [illegible] which documented diagnoses to include: Parkinson's [illegible] and Chronic [illegible]. The 1823 further documented in the [illegible] or Behavior Status: " [illegible] tries to get out of bed. " The 1823 documented

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A 025	Continued From page 2 Resident #1 ' s weight to be 60.59 kilograms which equals 133.59 pounds. During an interview conducted on at approximately 1:40 p.m. with Staff member J, a Resident Aid, she stated that she had found Resident #1 with her head completely between the side rail and the mattress with her feet hanging on the floor approximately 1 year ago. No documentation of this event was available for review. During a record review on of Resident #1's clinical chart a Resident Note, documented as a late entry for stated: " 13:50 Resident found between bed and railing, no injuries noted by Med Tech. Message left on POA (Power of Attorney) phone. It was noted that no documentation was present that would indicate that the physician had been contacted regarding the event. During a review of a facility summary of the event involving Resident #1 revealed that the question of " was the physician notified " documented to be " no " . No documentation was present on the event report that would indicate that the facility reviewed the event for potential hazards. During a record review on of Resident #1's clinical chart, a Resident Note, documented date of entry of stated: 04:45 Resident found on floor near bed by RCA (Resident Care Aid). According to med Tech no injuries noted, daughter notified. During a record review on of a facility summary of the event involving Resident #1 revealed that the question of " was the physician notified " documented to be "no."	A 025		

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A 025	Continued From page 3	A 025		

During a record review on [redacted] of Resident #1's Resident Notes, a dated entry of [redacted] documented that Resident #1 was found by staff unresponsive and not breathing at 0550, 911 called and [redacted] started, transported to ER (Emergency [redacted] by ambulance.

During a record review of a facility summary on [redacted] for the [redacted] event involving Resident #1, it stated: Resident appeared to be trying to get out of bed and was found between the bed and railing.

During a phone interview conducted on [redacted] at 4:00 p.m. with direct care staff member A, it was confirmed that she was working on [redacted] in the hallway where Resident #1 was located. Staff member A stated that after finishing up a check & change (approximately 5:45 a.m.) of a resident in the [redacted] the hallway from Resident #1, she walked into Resident #1 ' s [redacted] observed Resident #1 positioned with her head lodged face down between the mattress and bed-rail, the rest of the resident's body was hanging off the bed, the resident's knees were on the floor giving the resident leverage to stay in up position. Resident #1 was observed by Staff member A to be without pulse & heartbeat. She further stated that staff initiated [redacted] for Resident #1 and that the resident was transported to a local hospital.
During an interview conducted on [redacted] at 4:00 p.m. with Staff member A, she was asked if Resident #1 had been observed to have a similar event involving her bed rail before this occurrence, to which she stated that she " heard it happened before " but never witnessed it .
A review of the facility Admission and Discharge log on [redacted] documented Resident #1

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A 025	Continued From page 4 ... on ... During an interview conducted on ... at 1:30 p.m. with the Maintenance Director, he confirmed that the bed utilized by Resident #1 had been removed from the facility by family members of Resident #1. During an interview conducted at 1:40 p.m. with a Resident Care Aid (RCA), J, she was able to confirm and show the surveyors a bed mattress that was the same type as what was utilized by Resident #1. An observation was conducted of a metal health bed, located in ... the bed had a crushable vinyl mattress present with ½ side rails. An observation of approximately 3 inches of space was available between the mattress and the side rail. When the mattress was depressed from the side, it gave way to allow approximately 4-5 inches of space between the mattress and the side rail. Further review of the space between the side rail and the mattress revealed that the surveyor of slight build could position her upper torso between the mattress and the side-rail creating an entrapment hazard. During the mattress review, the Executive Director acknowledged that a review of the potential hazards of the space between the mattress and the side rail had not been conducted by the facility. It could be determined that the facility failed to analyze the entrapment hazard created by the vinyl mattress and the side rail spacing during the 1st documented occurrence of Resident #1 being found on ...'s event through the date of survey on ... A review was conducted on ... at approximately 4:00 p.m. of the facility's beds and it was found that 28 of the facility's 133 beds had	A 025		

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A 025	Continued From page 5 the crushable vinyl mattress with side rails present creating a current potential entrapment hazard. Class I	A 025		
A 030	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of the Florida Hotline " 1(800)9€ or	A 030		

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A 030	Continued From page 6	A 030		

1(800)962-2873 " shall be posted in full view in a common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.
(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.
(g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.
(h) Pursuant to Section 429.41, F.S., the use of physical shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including

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A 030	Continued From page 7	A 030		

half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the

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A 030	Continued From page 8	A 030		

facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a [redacted] his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.
(k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally [redacted], the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without [redacted] interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and

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A 030	Continued From page 9	A 030		

advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility A) failed to ensure that a physician ' s order for ½ bed rails was reviewed bi-annually by the ordering physician; B) failed to ensure that it documented the consent of the resident or the resident ' s representative for the ½ bedrails for 1 (#1) of 3 sampled residents.

Findings include:

A record review of Resident #1's clinical chart revealed that the resident admitted to the facility in ..... Further review of the chart revealed a Health Assessment, 1823, dated which documented diagnoses to include: Parkinson ' s , ... and Chronic .... The 1823 further documented in the or behavior status: " , tries to get out of bed. "

A record review of Resident #1 ' s clinical chart on ..... revealed a Home Health Agency ' s doctor ' s order, signed on , which documented " Hospital Bed ½ rails. No further updates regarding the order were available for review on the date of survey, which would have meant that 17 months had passed since the original order for the ½ hospital bed rails.

A further review on ..... of Resident #1 ' s clinical chart revealed no Consent form regarding the use of half-bed rails.

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A 030	Continued From page 10 During an interview conducted on [redacted] at approximately 2:30 p.m. with the Quality Service Manager, she confirmed that she was unaware that the physician ' s order for side rails needed to be updated on a bi-annual basis. The Quality Service Manager also confirmed that she was unaware that a Consent for the ½ side rails needed to be obtained from the resident or the resident ' s representative. CLASS III	A 030		
A 076	58A-5.0186 FAC (1) POLICIES AND PROCEDURES. (a) Each assisted living facility (ALF) must have written policies and procedures, which delineate its position with respect to state laws and rules relative to [redacted]. The policies and procedures shall not condition treatment or admission upon whether or not the individual has executed or waived a [redacted]. The ALF must provide the following to each resident, or resident ' s representative, at the time of admission: 1. A copy of Form SCHS-4-2006, " Health Care Advance Directives - The Patient ' s Right to Decide, " [redacted] 2006, or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in Chapter 765, F.S. Form SCHS-4-2006 is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308, or the agency ' s Web site at: http://ahca.myflorida.com/MCHQ/Health_Facility_	A 076		

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A 076	Continued From page 11 Regulation/HC_Advance_Directives/docs/adv_dir .pdf; and 2. Written information concerning the ALF ' s policies regarding ; and 3. Information about how to obtain DH Form 1896, Florida Form, incorporated by reference in Rule 64J-2.018, F.A.C. (b) There must be documentation in the resident ' s record indicating whether or not he or she has executed a . If a has been executed, a copy of that document must be made a part of the resident ' s record. If the ALF does not receive a copy of a resident ' s executed , the ALF must document in the resident ' s record that it has requested a copy. (2) LICENSE REVOCATION. An ALF shall be subject to revocation of its license pursuant to Section 408.815, F.S., if, as a condition of treatment or admission, it requires an individual to execute or waive a (3) PROCEDURES. Pursuant to Section 429.255, F.S., an ALF must honor a properly executed as follows: (a) In the event a resident experiences staff trained in or a licensed health care provider present in the facility, may withhold (b) In the event a resident is receiving hospice services and experiences facility staff must immediately contact the hospice. The hospice procedures shall take precedence over those of the assisted living facility. (4) LIABILITY. Pursuant to Section 429.255, F.S., ALF providers shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional	A 076		

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A 076	Continued From page 12 conduct, for following the procedures set forth in subsection (3) of this rule, which involves withholding or withdrawing pursuant to a Order and rules adopted by the department. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility A) Failed to ensure that it comprehensively provided a copy of Form SCHS-4-2006, " Health Care Advance Directives - The Patient ' s Right to Decide, " 2006, or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in Chapter 765, F.S. Form SCHS-4-200 for 3 (#1, 2 , 3) of 3 sampled residents; B) Failed to ensure that it provided each resident or family member written information concerning the facility ' s policies regarding for 3 (#1, 2, 3) of 3 sampled residents; C) Failed to ensure that the resident record contained documentation of whether or not the resident had executed a for 1 (#1) of 3 sampled residents. Findings include: A record review on of the facility ' s sample admission packet revealed no evidence that the facility was providing residents with a copy of Form SCHS-4-2006, " Health Care Advance Directives - The Patient ' s Right to Decide, " 2006, or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in Chapter 765, F.S. Form	A 076		

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ELMCROFT OF CARROLLWOOD	2626 WEST BEARSS AVENUE CARROLLWOOD, FL 33618

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A 076	Continued From page 13 SCHS-4-20006. A record review on [redacted] of the facility ' s sample admission packet revealed no evidence that the facility was providing residents or family members with written information concerning the facility ' s policies regarding [redacted]. During a record review on [redacted] of Resident #1, 2 and 3 ' s clinical file revealed no documentation of the latter information. During a record review on [redacted] of Resident #3 ' s clinical file revealed no documentation of whether or not the resident had executed a [redacted]. The facility file revealed no presence of a [redacted] order. During an interview conducted on [redacted] at 10:45 a.m. with the Marketing Director confirmed that he was unaware of the requirement to provide the information concerning Advance Directives and the facility policy on [redacted] to residents admitting to the facility. The Marketing Director also confirmed that no process was in place to ensure that documentation was completed on whether or not a resident had executed a [redacted]. Class III Widespread	A 076		

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Elmcroft of Carrollwood
2626 West Bearss Avenue
Carrollwood, FL 33618

Dear Administrator:

Re: **CCR# 2012006033 & CCR# 2012008656**

This letter reports the findings of two complaint surveys that were conducted on , 2012, by representatives of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia Reid Putman
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1161