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
	AL11964567	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT CARROLLWOOD	13550 SOUTH VILLAGE DRIVE TAMPA, FL 33624

(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 Assisted Living Facility Complaint surveys, CCR# 2012009925 & CCR# 2012010490, were conducted on [redacted]. The Emeritus at Carrollwood, assisted living facility, had deficiencies found at the time of the visit.	A 000		
A 010	58A-5.0181(4) FAC Admissions - Continued Residency (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (e) of this subsection, criteria for continued residency in any licensed facility shall be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a face-to-face medical examination by a licensed 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 58A-5.0131, 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. The form must be completed in accordance with that paragraph. After the effective date of this rule, providers shall have up to 12 months to comply with this requirement. (a) The resident may be bedridden for up to 7 consecutive days. (b) A resident requiring care of a [redacted] pressure [redacted] may be retained provided that: 1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a licensed health care provider, or the resident contracts directly with a licensed home health agency or a nurse to provide care;	A 010		

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A 010	Continued From page 1	A 010		

2. The condition is documented in the resident ' s record; and
3. If the resident ' s condition fails to improve within 30 days, as documented by a licensed health care provider, the resident shall be discharged from the facility.
(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:
1. The resident qualifies for, is admitted to, and consents to the services of a licensed hospice which coordinates and ensures the provision of any additional care and services that may be needed;
2. Continued residency is agreeable to the resident and the facility;
3. An interdisciplinary care plan is developed and implemented by a licensed hospice in consultation with the facility. Facility staff may provide any nursing service permitted under the facility ' s license and total help with the activities of daily living; and
4. Documentation of the requirements of this paragraph is maintained in the resident ' s file.
(d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility.
(e) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C.
(5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident ' s needs, as determined by the facility administrator or licensed health care provider, the resident shall be discharged in accordance with Section 429.28(1), F.S.

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A 010	Continued From page 2	A 010		

This Statute or Rule is not met as evidenced by:
Based on record review and staff interview, the facility did not ensure the health assessment (1823) was updated after a change in condition for 1 (#1) of 3 residents review.

Findings include:

1. Review of the record for resident #1 revealed the resident was admitted on as an independent resident. A review of the health assessment (1823) dated noted the resident to have diagnosis of and insufficiency. The health assessment noted the resident to be independent with all activities of daily living and managed his own medication without over-sight from the facility.

According to information received during interviews from facility staff at 11:30 a.m. and the previous facility LPN via phone call at 12:45 p.m., the resident began showing signs of and when they checked on the resident, it was evident he was not taking his medications consistently. Upon realizing the resident was not self-managing his medications properly 2012) the facility began assisting the resident with medications and implementing routine checks on the resident including reminders to come for meals.

The LPN stated he had the residents health assessment updated after the change in the residents condition.

A review of the records for resident #1 included the medical record & business file. There was no

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A 010	Continued From page 3 evidence of an updated health assessment found. Class III CCR# 2012009925	A 010		
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 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	A 025		

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A 025	Continued From page 4 administration, or other changes which resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based upon record review and staff interview the facility failed to document significant events concerning a change in the health status of 1 (#1) of 3 residents reviewed requiring the provision of additional services. Findings include: Review of resident #1's record revealed who was admitted as an independent resident in 2012, experienced a change in health status on or about 2012 requiring a higher level of assistance. Per interview with direct care staff, and management, and a former DON (11:30am, 12:45pm respectively), the resident had been independent with self-administered medications from admission. The resident kept his medications in his going to staff when he needed a prescription refilled. The direct care staff/wellness director said (11:30 a.m.) that she noticed a problem concerning the resident not taking his medications properly when he came to her asking for help re-filling his prescriptions. When she called the pharmacy she was told that resident either already received his refills or it was too early to refill a prescription. Upon hearing this the Wellness Director went to the residents completed a review of the residents medications. She said it was evident from looking at the medication bottles that resident #1 had not been taking his medications consistently. She added that the facility	A 025		

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A 025	Continued From page 5 immediately began assisting the resident with his medications the next morning. During telephone interview with the former facility DON at 12:45 p.m. on [redacted] he said that the facility reviewed medications that the resident had in his [redacted] also reviewed an independent medication list provided from one of the pharmacies that were re-filling the medications for resident #1. He also said he did not know the resident had been taking a [redacted] since it was not one of the prescription bottles taken from the resident [redacted] not on the pharmacy list for re-fills. He added that once the facility began assisting the resident with his medications, it wasn't until the resident came to him, about 3 days later asking for his water pill that the DON contacted the physician and obtained an order for Torsemide [redacted]. A review of the medication observation record for resident #1 revealed the facility began assisting the resident with medications on the evening of [redacted] 2012. The first dose of Torsemide [redacted] was not given until [redacted]. This medication was discontinued on [redacted] by the physician per orders on file and replaced with [redacted] 40 m.g. on [redacted]. Per documentation on facility service notes dated [redacted] the [redacted] was requested by family & resident instead of the Torsemide. There was no documentation in the facility progress notes of the events leading up to the residents change in health status, identification of the resident not self-administering his own medications accurately/consistently or the need for closer supervision. The documentation was lacking in the details that lead up to the interventions put in place by the facility.	A 025		

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A 025	Continued From page 6 Class III CCR# 2012009925	A 025		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Emeritus at Carrollwood
13550 South Village Drive
Tampa, FL 33624

Dear Administrator:

Re: **CCR# 2012009925 & CCR# 2012010490**

This letter reports the findings of two complaint surveys that were conducted on , 2012, by a representative 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 surveyor. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

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