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
	AL11967960	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A NEW AGE OF SENIOR CARE AT WELLINGTC	1074 C/D HYACINTH PLACE WELLINGTON, FL 33414

(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 An Assisted Living Facility standard biennial licensure survey was conducted on . A New Age of Senior Care at Wellington, had licensure deficiencies found at the time of the visit.	A 000		
A 010 SS=D	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 : pressure . . . 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; 2. The condition is documented in the resident ' s record; and 3. If the resident ' s condition fails to improve	A 010		

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A 010	Continued From page 1	A 010		

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 This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure a Health Assessment, AHCA Form 1823 was completed on every resident upon significant change and that it is reflective of the resident's current health status and care needs, for 1 out of 6 sampled residents (Resident #1). The findings include: Record review indicated an admission date of . Review of a health assessment dated , documented a medical diagnosis of and . Further record review revealed Resident #1 was admitted/enrolled in Hospice on . During an interview with the Administrator at 1 PM on , it was revealed the resident was admitted to hospice for and the resident had declined in health since admission. Further record review failed to indicate a current health assessment since the significant health change of the resident and admission to hospice. Further interview with the Administrator, revealed the facility did not have a current health assessment reflecting the current health changes and current ADLs level for the resident. Class III	A 010		
A 011 SS=D	58A-5.0181(5) FAC Admissions - Discharge (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. This Statute or Rule is not met as evidenced by:	A 011		

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A 011	Continued From page 3	A 011		

Based on observation, record review and interview, it was determined the facility failed to discharge a resident who requires nursing services for 1 out of 6 sampled residents (Resident #6).

The findings include:

Resident #6's was observed at approximately 9:30 AM and 1 PM on with a foot/ankle brace on her right foot. An interview with the Administrator at 10 AM on revealed the resident was in a rehabilitation center after suffering from a at the facility on and was readmitted to the facility on with the brace on her right foot/ankle. It was revealed the facility's unlicensed staff is responsible for ensuring that the brace is placed on the resident appropriately on a daily basis. An interview with the resident at 9:45 AM on revealed the resident is not fully alert and oriented and was noted to be mildly

Review of Resident #6's health assessment dated , documented a medical diagnosis of and The Health Assessment also documented the resident required supervision with ambulation and assistance with transfer.

During an interview with the Administrator and Manager at approximately 10:45 AM on 10/3 was revealed the facility applied an electric bone stimulator on the resident's ankle (right ankle, front middle area) daily for 20 minutes. It was revealed the facility was informed how to apply and operate the stimulator by the resident's daughter prior to usage and manufactures

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A 011	Continued From page 4	A 011		

instructions were also provided in the stimulator kit. This was also confirmed during an interview on [redacted] at 12:45 PM with the resident's daughter and observations of the machine. The daughter revealed she was informed by her mother's physician that the unlicensed staff at the facility could operate the machine daily on behalf of the resident.

Review of the facility's license revealed the ALF has a standard license. Further interview with the Administrator and the Manager confirmed that the facility does not employ a nurse or have a Limited Nursing Service license to perform the nursing needs with respect to the bone stimulator and monitoring the brace for Resident #6. It was also revealed the resident is receiving home health services for physical 3 times a week at the facility. According to the Administrator the physical does not include the application and monitoring of the bone stimulation for the resident.

Class III

A 160 SS=D	58A-5.024(1) FAC Records - Facility	A 160		

Records.
The facility shall maintain the following written records in a form, place and system ordinarily employed in good business practice and accessible to Department of Elder Affairs and Agency staff.
(1) FACILITY RECORDS. Facility records shall include:
(a) The facility ' s license which shall be displayed in a conspicuous and public place within the facility.
(b) An up-to-date admission and discharge log

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listing the names of all residents and each resident ' s:
1. Date of admission, the place from which the resident was admitted, and if applicable, a notation the resident was admitted with a pressure and
2. Date of discharge, the reason for discharge, and the identification of the facility to which the resident is discharged or home address, or if the person is the date of
Readmission of a resident to the facility after discharge requires a new entry. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intends to return pursuant to Rule 58A-5.025, F.A.C.
(c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b).
(d) An up-to-date record of major incidents occurring within the last 2 years. Such record shall contain a clear description of each incident; the time, place, names of individuals involved; witnesses; nature of injuries; cause if known; action taken; a description of medical or other services provided; by whom such services were provided; and any steps taken to prevent recurrence. These reports shall be made by the individuals having first hand knowledge of the incidents, including paid staff, volunteer staff, emergency and temporary staff, and student interns.
(e) The facility ' s emergency management plan, with documentation of review and approval by the county emergency management agency, as described under Rule 58A-5.026, F.A.C., which shall be located where immediate access by facility staff is assured.
(f) Documentation of radon testing conducted

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pursuant to Rule 58A-5.023, F.A.C.;
(g) The facility ' s liability insurance policy required under Rule 58A-5.021, F.A.C.;
(h) For facilities which have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C.
(i) The admission package presented to new or prospective residents (less the resident ' s contract) described in Rule 58A-5.0182, F.A.C.
(j) If the facility advertises that it provides special care for persons with [redacted] or related [redacted], a copy of all such facility advertisements as required by Section 429.177, F.S.
(k) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C.
(l) All food service records required under Rule 58A-5.020, F.A.C., including menus planned and served; county health department inspection reports; and for facilities which contract for catered food services, a copy of the contract for catered services and the caterer ' s license or certificate to operate.
(m) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last two (2) years.
(n) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years.
(o) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years.
(p) Additional facility records requirements for

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facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively.
(q) The facility ' s resident elopement response policies and procedures.
(r) The facility ' s documented resident elopement response drills.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to ensure detailed and complete records (incident reports) are maintained for all major incidents or significant changes involving a resident, for 1 out 6 sampled residents (Resident #6).
The findings include:
Review of Resident #6's health assessment dated documented a medical diagnosis of a and . The health assessment also documented the resident requires supervision with ambulation and assistance with transfer.

a) Review of incident report dated documented the following incident for Resident #6. Resident #6 was walking around she twisted to get a teddy bear off the and tripped on her walker. Staff heard the commotion and rushed to the find her on the floor. There was obvious deformity, so 911 was called. Further review of the incident report revealed the facility failed to document any steps taken to prevent recurrence. During an interview with the Administrator at 12:50 AM, it was revealed no further

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A 160	Continued From page 8 documentation was available for review. b) During an interview with the Administrator at 10 AM on , it was revealed Resident #6 in her . Review of Resident #6's file failed to indicate this event or document the occurrence of the event including witnesses involved, appropriate persons notified and any steps taken to prevent reoccurrence. Upon request of documentation of the incident from the facility, the facility's communication log was provided for review. Review of the facility's communication log documented that on at approximately 4 AM, resident got up out of bed and hit head on walker. It was noted that the log failed to document the nature of the injury, services provided with respect to the injury, notification to appropriate persons and steps taken to prevent reoccurrence. An interview with the Administrator at 11:40 AM on revealed the facility had not completed an incident report or documented in the resident's file in full detail regarding the event. However, it was revealed by the Administrator that the resident's physician and legal guardian were notified on the same date, which was confirmed by the legal guardian during an interview on at 12:45 PM. According to the Administrator, no further documentation was available for review. Class III	A 160		
A 162 SS=D	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records shall be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name; 2.	A 162		

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3. Race;
4. Date of birth;
5. Place of birth, if known;
6. Social security number;
7. Medicaid and/or Medicare number, or name of other health insurance
8. Name, address, and telephone number of next of kin, responsible party, or other person the resident would like to have notified in case of an emergency, and relationship to resident; and
9. Name, address, and phone number of health care provider, and case manager if applicable.

(b) A copy of the medical examination described in Rule 58A-5.0181, F.A.C.

(c) Any health care provider ' s orders for medications, nursing services, therapeutic diets, or other services to be provided. supervised, or implemented by the facility that require a health care provider ' s order.

(d) A signed statement from a resident refusing a therapeutic diet pursuant to Rule 58A-5.020, F.A.C.

(e) The resident record described in paragraph 58A-5.0182(1)(e), F.A.C.

(f) A weight record which is initiated on admission. Information may be taken from the resident ' s health assessment. Residents receiving assistance with the activities of daily living shall have their weight recorded semi-annually.

(g) For facilities which will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident ' s contract.

(h) For facilities which manage a pill organizer, assist with self-administration of medications or administer medications for a resident, the

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required medication records maintained pursuant to Rule 58A-5.0185, F.A.C.
(i) A copy of the resident ' s contract with the facility, including any addendums to the contract, as described in Rule 58A-5.025, F.A.C.
(j) For a facility whose owner, administrator, or staff, or representative thereof serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required under Section 429.27, F.S.
(k) For any facility which maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required under Section 429.27, F.S.
(l) A copy of Alternate Care Certification for) Form, CF-ES 1006, 1998, if the resident is an recipient. The absence of this form shall not be considered a deficiency if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Family Services.
(m) Documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney where applicable.
(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required under Rule 58A-5.0181, F.A.C.
(o) For apartments, duplexes, quadruplexes, or single family homes that are designated for independent living but which are licensed as assisted living facilities solely for the purpose of delivering personal services to residents in their homes, when and if such services are needed, record keeping on residents who may receive meals but who do not receive any personal,

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limited nursing, or extended congregate care service shall be limited to the following:
1. A log listing the names of residents participating in this arrangement;
2. The resident demographic data required under this subsection;
3. The medical examination described in Rule 58A-5.0181, F.A.C.;
4. The resident ' s contract described in Rule 58A-5.025, F.A.C.; and
5. A health care provider ' s order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility.
(p) Except for resident contracts which must be retained for 5 years, all resident records shall be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents shall be provided a copy of their resident records upon departure from the facility.
(q) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to ensure that 2 out of 6 sampled resident records contained all of the required components (Resident #1 & #3).

The findings are:

During an interview with the Administrator at 9:45 AM on , it was revealed Resident #1 &

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A 162	Continued From page 12 #3 are enrolled and receiving services from Hospice. Review of Resident #1 & #3's records confirmed services provided by Hospice but lacked documentation of the interdisciplinary care plan. Upon request of this documentation from the Administrator on at approximately 1:00 PM, it was revealed the facility did not have the interdisciplinary care plan for Resident #1 & #3, as required. Class III	A 162		
A 167 SS=D	58A-5.025(1) FAC Resident Contracts Resident Contracts. (1) Pursuant to Section 429.24, F.S., prior to or at the time of admission, each resident or legal representative shall execute a contract with the facility which contains the following provisions: (a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services if the facility is licensed to provide such services. (b) The daily, weekly, or monthly rate. (c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule which shall be attached to the contract. (d) A provision giving at least 30 days written notice prior to any rate increase. (e) Any rights, duties, or of residents, other than those specified in Section 429.28, F.S. (f) The purpose of any advance payments or deposit payments and the refund policy for such advance or deposit payments. (g) A refund policy which shall conform to Section 429.24(3), F.S. (h) A written bed hold policy and provisions for	A 167		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A NEW AGE OF SENIOR CARE AT WELLINGTC	1074 C/D HYACINTH PLACE WELLINGTON, FL 33414

(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
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terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or facility. The resident or responsible party shall notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident ' s medical condition, such as the resident ' s being comatose, prevents the resident from giving written notification and the resident does not have a responsible party to act in the resident ' s behalf.
(i) A provision stating whether the organization is affiliated with any religious organization, and, if so, which organization and its relationship to the facility.
(j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those the facility is licensed to provide, the resident or the resident ' s representative, or agency acting on the resident ' s behalf, shall be notified in writing that the resident must make arrangements for transfer to a care setting that has services needed by the resident. In the event the resident has no person to represent him, the facility shall refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions as outlined in Section 429.26(8), F.S., shall take effect.
(k) A provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule.
(l) The facility ' s policies and procedures for self-administration, assistance with

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
	AL11967960	A. BUILDING _____ B. WING _____	

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A NEW AGE OF SENIOR CARE AT WELLINGTC	1074 C/D HYACINTH PLACE WELLINGTON, FL 33414

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A 167	Continued From page 14	A 167		

self-administration and administration of medications, if applicable, pursuant to Rule 58A-5.0185, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule.
(m) The facility ' s policies and procedures related to a properly executed

This Statute or Rule is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to maintain current executed contracts for each sampled resident, for 2 out of 6 sampled residents (Resident #1 & #3).

The findings include:

a) Review of Resident #1's contract dated noted a monthly rental amount of $3000. During an interview with the Administrator at 1 PM on , it was revealed the resident pays $4000 monthly. Upon request of the current contract reflecting this amount, it was revealed by the Administrator that he did not have an updated contract or addendum reflecting the current residency agreement amount of $ 4000 per month.

b) Review of Resident #3's contract dated documented a monthly rental amount of $6000. During an interview with the Administrator at 1:30 PM on , it was revealed the resident pays $5500 monthly. Upon request of the current contract reflecting this amount, it was revealed by the Administrator that he did not have an updated contract or addendum reflecting the current residency agreement amount of $ 5500 per month.

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
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RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
A New Age Of Senior Care At Wellington, Inc
1074 C/D Hyacinth Place
Wellington, FL 33414

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2012 by a representative from 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 (30) days** of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , **2012** 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Monica Thurman-Smith

/for/ Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

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