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
	AL11965818	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT LAKE MARY	150 MIDDLE STREET LAKE MARY, FL 32746

(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 complaint inspection CCR #2012008536 was conducted on . The complaint was substantiated and deficiencies were found during the visit.	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 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.	A 025		

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A 025	Continued From page 1	A 025		

This Statute or Rule is not met as evidenced by:
Based on observation, resident record and interview the facility failed to provide care, supervision and services appropriate to meet the needs and ensure the safety through proactive measures to minimize the potential for and injuries and resident's behaviors resulting in numerous with injuries and resident on resident altercations in the memory care unit for 8 of 13 sampled residents (#2, #3, #5, #6, #7, #9, #10 and #13)

Findings:

Information was obtained that the resident's in the memory care unit were having numerous falls there were also altercations in the unit between residents that resulted in injuries. Review of event management forms and service notes revealed the following:

1. Record review for resident #3 revealed a resident health assessment form 1823 that was dated 5/1 diagnosis of Dementia History Abdominal Special precautions: safety awareness.
An Emeritus event Management form 4/2 sident#3 wandered into another residents room mentioned) he grabbed her hand/wrist and twisted it. Swelling to wrist. Injury outcome-fracture. taken-Family was notified and request that Ice be applied and an x-ray be done in the morning. PCP notified. x-ray results revealed a fracture her left wrist, resident was sent out to the hospital and returned with cast.
granddaughter she asked that she remain in community and have ice applied and x-ray in the morning.

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A 025	Continued From page 2	A 025		

A preliminary report was faxed to the facility at 6:14 PM on
X-ray was conducted on . The report dated at 9:43 AM noted: There is an acute-looking Colles type with ventral angulations. Impression: acute looking Colles type wit ventral angulations. Degenerative bony changes are noted at the

Service notes noted the following:
time) health care provider was contacted and he requested to send the resident to the ER. Resident was sent to the ER.
PM-resident returned to the facility from hospital at 4:15 AM. Resident had a on left arm.

2. Record review for resident #9 revealed an 1823 that was dated with diagnosis that included insufficiency, . Further record review revealed the following behaviors:
per staff resident has been very combative with other residents and staff; per staff when trying to talk to resident he gets very upset. Health Care provider communication form-Per staff, resident has been very combative may we have an order for UA/C&S . Health care provider communication form. Per staff resident was found fighting with no injuries noted
PM- resident became upset with another resident over clothing resulting in altercation with the other resident, losing his balance and falling onto the floor and sustaining a . Residents separated and closet labeled with names, family and PCP notified time), had an altercation with another resident. POA was notified and Primary Care Physician (PCP). Resident was sent to hospital

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A 025	Continued From page 3	A 025		

for Eval via non emergency ambulance.
(1) resident twisted another resident wrist last night. (2)Pushed another resident this AM (3) and had an altercation with another resident.
-12:40 PM resident returned- to facility this morning at 3:30 AM; no combative behaviors noted, will continue to monitor.
observed in his his hands around the neck of another resident in MCN (#7). The other resident was unresponsive for a short time and was sent out to the hospital. The resident will be immediately discharged from community. Resident was sent to the emergency further evaluations.
Further record review revealed that the only time a psych evaluation was requested was on . There was no documentation that the heath care provider was spoken to regarding the resident's combative behaviors in order to determine the services that could be put in place to help the resident. As a result of his behavior he twisted resident #3's arm causing her to sustain a of the wrist and was found with his hands around the neck of resident #7 causing him to become unresponsive.
The Resident care director stated that during the first behavior in the resident possibly had an ear that may have caused his behavior problems. According to the service notes the resident had 3 altercations with other residents in one day on and there was no documentation found in the record of the interventions that were put in place to assure that the resident would be monitored to ensure that he and the other resident's in the memory care unit were safe.

3. Record review for Resident #7 revealed an 1823 that was dated with diagnosis that included

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A 025	Continued From page 4	A 025		

disorder ... Dementia. ... of the facility's event management reports and service notes revealed that the resident had 16 falls ... 3/2... 10/2... resulting in him hitting his head, obtaining skin ... lacerations and being sent out to the hospital. Resident #7 was observed throughout the survey walking around the memory care unit without assistance.

A service note documented on 6/1... 11:08 am that the resident was sent to the hospital because he was sitting in a chair and leaned forward while sleeping and fell ... and sustained a laceration to his forehead. 911 was called to transport him to the hospital.

Further record review revealed the following behaviors:

Service note date 1/2... time noted)-notified by CNA every shift that resident was combative and agitated resident hurt CNA by grabbing her and kicking her.

4/23/12-... had an altercation with another resident last night. Resident has a skin ... his left arm below his elbow

4/2... 30 PM-Resident had an altercation with another resident and was sent to the hospital for evaluation.

5/17/1... management report noted the resident was pulling and combative. A bruise ... noted on his left arm

Event management report dated ... 11:30 PM noted resident entered another resident's room; ... resident stated that he "socked me in my jawbone". No injury noted to this resident, however the other resident obtained two skin tears.

A service note documented on 6/2... time) the resident became angry when asked to leave a room ... had wandered into and threw himself onto the floor.

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A 025	Continued From page 5 A service note documented on ... at 10 AM-resident eloped from the memory care unit at 5:45 AM; exited out back fire door, alarm sounded staff responded to find him exiting the back gate. Resident walked out to front of building and was returned to unit unharmed; no injuries noted. Further record review revealed that the resident was admitted to hospice on .. Continue record review revealed that there was no documentation to confirm the proactive measures that facility had instituted to ensure that the resident was safe, nor was there a plan coordinated with the hospice agency and the facility to keep the resident safe, there was no documentation of the proactive measures in place to minimize the potential ... There was also no documentation to confirm that the facility had spoken with the health care provider regarding the ... and the behaviors that the resident was exhibiting. 4. Record review for resident #10 revealed an 1823 that was dated ... with diagnosis of A-Fib, ... and ... and history of frequent ... with a recent ...l the 1823 noted special precautions: ... precautions. Review of the facility' s event management reports and service notes revealed that the resident had 20 ... from ... through ... some resulting in him hitting her head, obtaining ... and lumps to the head and being sent out to the hospital. Resident #10 was observed throughout the survey alone in her ... The staff stated she like staying in her ... A service note documented on ... at 3 PM the resident was found on the floor. Resident stated that she ... and hit her head on the same spot. 911 was called because she was complaining of ...	A 025		

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A 025	Continued From page 6 Continue record review revealed that there was no documentation to confirm the proactive measures that facility had instituted to ensure that the resident was safe and the proactive measures that were in place to minimize the potential .... 5. Resident Record Review on ....: revealed that the resident has a Facility Health Assessment Form (1823) dated .... that has diagnosis of .... neck of femur, Joint pain, AMS, ..., difficulty walking. The assessment further noted that the resident requires assistance with self-administration of medication and assistance with all Activities of Daily Living. Review of facility incident reports revealed: .... Resident found on floor, first aide administered to ....: Altercation with another resident, ... to arm treated. ....: got into altercation with another resident no injuries noted .... Altercation with another resident .... treated to right arm. ....: Resident found on .... to great toe right foot. .... Resident pushed by another resident .... to floor complained of pain in left leg. 911 took resident to hospital. Resident sustained .... of left hip. ....: Resident returned to facility from Rehab within 3 hours resident .... to floor 911 called and resident taken to hospital where she was readmitted. .... Found on floor in .... to foot. Found on floor in another resident .... No injuries noted .... Resident found on floor, no injuries	A 025		

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A 025	Continued From page 7	A 025		

noted.
Resident found on floor no injuries noted.
Resident #5
6. Resident Record Review on at approximately 2:00PM for Resident #5 revealed a Facility Health Assessment Form (1823) dated with diagnosis of s, ambulation with assist x1, It was further noted that she needs assistance with self- administration of medication and assistance with all her activities of daily living.
Review of Facility Incident Reports revealed:
Resident found on floor above right eye.
Resident found on floor to right arm.
Resident found on floor 911 to hospital returned next shift.
Resident found on floor at 4:30 Pm, possible 911 called; resident transported to hospital and admitted.
Resident found on floor x2 head 911 transported resident to hospital x-ray and
Resident found on floor at 3:10AM possible head 911 called, Residents daughter said do not transport.
10:00 AM Physician contacted ordered resident sent to hospital for evaluation and Returned to facility on 3-11 shift.
7. Resident Record Review on at approximately 2:20 PM revealed a Facility Health Assessment Form (1823) dated with diagnosis of S/P left hip , Reoccurring , A-Fib, Failure, and Debility.
The form cited further that the resident requires assistance with self-administration of medications and assistance with all activities of daily living.

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A 025	Continued From page 8 Review of facility incident reports revealed: found on floor no injuries found on floor complained of pain in lower leg. found on floor no complaint of pain no injuries noted found on floor no injuries noted. Staff found on floor, Injury to left hip. x-ray to left hip to floor laceration to head. found sitting on floor on floor. found on floor in common area no injuries noted on floor laceration over right eye. 911 to hospital diagnosed with minor closed had injury w/o loss of , superficial to head. Returned to facility with wheel chair hit forehead small open area on forehead treated. 8. Resident Record Review on revealed a Facility Health Assessment (1823) dated with diagnosis of , PPH, OP, , , CZ Spine , Left hip and use of super pubic . It was noted that he requires assistance with self-administration and assistance with all activities of daily living. Review of Facility Incident Reports revealed: Found on floor laceration to head. 911 to hospital for returned to facility. found on floor 6:30PM, 911 to hospital for evaluation returned to facility on 11-7 shift. found on floor no injuries noted. to floor no injuries noted. found on floor first aide to right arm.	A 025		

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A 025	Continued From page 9 ... found on floor, first aide given. Class II	A 025		
A 052	58A-5.0185(3) FAC Medication - Assistance with Self-Admin (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) For facilities which provide assistance with self-administered medication, either: a nurse; or an unlicensed staff member, who is at least ..., trained to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the administrator the ability to accurately read and interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. (b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container. (c) Staff shall observe the resident take the medication. Any concerns about the resident's reaction to the medication shall be reported to the resident's health care provider and documented in the resident's record. (d) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to	A 052		

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A 052	Continued From page 10	A 052		

enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule which coincides with the resident ' s presence in the facility;
2. The medication container may be given to the resident or a friend or family member upon leaving the facility, with this fact noted in the resident ' s medication record;
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident ' s medication record; or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging;
(e) Pursuant to Section 429.256(4)(h), F.S., the term " competent resident " means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication.
(f) Pursuant to Section 429.256(4)(i), F.S., the terms " judgment " and " discretion " mean interpreting vital signs and evaluating or assessing a resident ' s condition.
(4) Assistance with self-administration does not include:
(a) Mixing, converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.
(b) The preparation of syringes for injection or the administration of medications by any injectable route.
(c) Administration of medications through intermittent positive pressure breathing machines or a

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A 052	Continued From page 11 (d) Administration of medications by way of a tube inserted in a cavity of the body. (e) Administration of preparations. (f) Irrigations or debriding agents used in the treatment of a skin condition. (g) or preparations. (h) Medications ordered by the physician or health care professional with prescriptive authority to be given " as needed, " unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (i) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. This Statute or Rule is not met as evidenced by: Based on observations and interview the facility failed to ensure when unlicensed staff provided assistance with the self-administration of medications, the staff followed the appropriate procedure at all times and did not 1. Take the Medication, in its dispensed, properly labeled container, from where it was stored and brought to the resident. 2. In the presence of the resident, read the label, open the container, remove a prescribed amount of medication from the container, and close the container. Findings: When entering the facility on at approximately 9:15 AM a staff was observed with pills in a small white cup on the medication cart, she was observed handing the cup to a resident who was sitting in the hallway in front of the medication cart for her to take. Further	A 052		

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A 052	Continued From page 12 observations revealed that after the resident was finished with the medication that was inside the cup, she was handed another small cup and the resident was observed taking that medication also. The staff was asked at the time if she was she was a nurse. She stated that she was not. She was asked if she had read the label to the resident before giving her the medications, she stated no. She was asked if she had been trained on the proper procedure when providing assistance with self-administrations medications and she stated that she had been trained. The staff did not take the Medication, in its dispensed, properly labeled container, from where it was stored and brought to the resident. 2. In the presence of the resident, read the label, open the container, remove a prescribed amount of medication from the container, and close the container. Class III	A 052		

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Emeritus At Lake Mary
150 Middle Street
Lake Mary, FL 32746

Dear Administrator:

Re: CCR #2012008536

This letter reports the findings of a state licensure survey that was conducted on , 2012 by representative(s) 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 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 surveyor(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

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