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
	AL11966444	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGDON HALL, INC INDEPENDENT & ASSIS	1120 33 AVENUE WEST BRADENTON, FL 34205

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A 000	Initial Comments Assisted Living Facility A complaint survey, CCR # 2012011660, was conducted on and . The Langdon Hall, Inc. Independent & Assisted Living Facility had unrelated deficiencies found at the time of the visit.	A 000		
A 008	58A-5.0181(2) FAC Admissions - Health Assessment (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days prior to the individual ' s admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or services required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms of a communicable which is likely to be transmitted to other residents or staff; 7. A statement on the day of the examination that, in the opinion of the examining licensed health	A 008		

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A 008	Continued From page 1	A 008		

care provider, the individual ' s needs can be met in an assisted living facility; and
8. The date of the examination, and the name, signature, address, phone number, and license number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state.
(b) A medical examination completed after the resident ' s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ <http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/> Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows:
1. The resident ' s licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment.
a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion.
b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider.
c. Omitted information received verbally must be documented in the resident ' s record, including the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided.

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A 008	Continued From page 2	A 008		

2. The facility administrator, or designee, must complete Section 3 of the form, Services Offered or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the elements in Section 3. This requirement does not apply for residents receiving:
a. Extended congregate care (ECC) services in facilities holding an ECC license;
b. Services under community living support plans in facilities holding limited mental health licenses;
c. Medicaid assistive care services; and
d. Medicaid waiver services.
(c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual ' s admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823.
(d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b).
(e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule.
(f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the health assessment. A licensed health care provider may attach a do-not- order for residents who do not wish to be administered in the case of

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A 008	Continued From page 3 or (g) A resident placed on a temporary emergency basis by the Department of Children and Family Services pursuant to Section 415.105 or 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility ' s admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to have an appropriately completed health assessment (AHCA form 1823) for 1 of 11 (resident #9) census sampled residents. The health assessment form was not reviewed by the facility designee for completion following hospitalization. By not reviewing the health assessment, the proper services may not be put into place for the resident. Findings include: Resident #9 was missing whether or not they needed assistance with medications. Also incomplete are the self-care and general oversight assessment (section 2) and services offered or arranged by the facility (section 3). The health assessment form was last updated on after hospitalization. The resident has a history of and . An interview with the registered nurse on at approximately 11:00 a.m. revealed that she is responsible for making sure the health	A 008		

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A 008	Continued From page 4 assessment (ACHA form 1823) is complete. The registered nurse states that the records for Resident #9 are incomplete and the chart has not been updated with information or the medications were not checked since before or after the resident was sent out on and required medical attention for the from her head. By the facility not completing and reviewing the information on the health assessment they are unable to be sure that the resident is receiving the appropriate medications and treatment needed following the recent hospitalization. It was noted the resident was " from the head " on an incident report written on . The Health assessment form includes information that the resident needs home health services, labs and doctor follow up appointments. It is not clear that these services have been provided. On at approximately 10:00 am medications were found at the resident's bedside that were listed on the health assessment form. The resident had not been assessed on whether they were capable of managing their own medications.	A 008		
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.	A 025		

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A 025	Continued From page 5 (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. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to update the resident records with documentation that would assist in caring for the residents. 3 of 11 sampled residents, Residents #8,#9 and #11, incurred with injury that required medical attention . The facility places residents at risk by not letting other staff know the residents needs and therefore care may be delayed in treating the injuries that may occur related to accidents. Findings include: A record review of the communication log found on that Resident #8 had a " bad ". A record review of the notes for the resident does not mention the on or the care that was received for the injury that was a result of the . The resident notes reveal that the resident will receive red cell as needed, but is refusing weekly testing. The next	A 025		

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A 025	Continued From page 6	A 025		

note is that the resident refuses further testing and had a on , that required transfer to a local hospital and that a local home health agency was doing his care. The note also states that the resident " remains independent with ADL ' s(activities of daily living) and medications " . On Resident #8's health assessment (1823) the special precautions are listed as and . A record review of the communication log from to does not mention that the resident had a . There is no incident report written for the most recent that resulted in the resident requiring home health for dressing changes to the head .

Observation and interview on at approximately 4:00 pm with resident #8 revealed that he had sometime in the past few days and now has a bandage on the top of his head with red drainage. The resident is asking the surveyor when a nurse is coming to take care of this.

An interview with the Registered Nurse on at approximately 9:30 am revealed that Resident #8 had sometime earlier in the week. The registered nurse believes that it may have happened on Wednesday. The registered nurse stated that Resident #8 was sitting at the door asking when a nurse was going to take care of this and that the resident had placed a bandage on the top of his head. The registered nurse stated that she had called a local home health agency for care of the head . The home health agency was supposed to send out a nurse on , but the nurse came on . Interview with Resident #8 reveals that he " so much that he can ' t keep track of them " . The resident ' s record and interviews with the registered nurse does not reveal what is being done to protect and prevent the resident

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A 025	Continued From page 7	A 025		

from continuous injury from his . It is noted that the resident refuses . The resident has had two with injury that require nursing care since and the resident ' s records were not updated when medical attention was required.
A record review of the communication log found that Resident #9 was sent out on , once in the morning and returned, then sent out again in the afternoon. An incident was report was written on at 5:00 am stating the resident was " from the head " . Record review of the chart for Resident #9 revealed no doctor's orders and the last note made in the chart from the facility was on . The resident ' s health assessment form has not been signed as being reviewed by the facility. The information that was missing from the health assessment included whether or not the resident needs assistance with medications. The health assessment form was last updated on following hospitalization.
Interview with the registered nurse on at approximately 11:00 am revealed that she is responsible for making sure the health assessment (ACHA form1823) is complete. The registered nurse states that the records for Resident #9 are incomplete and the chart has not been updated with information or the medications were not checked before the resident was sent out or after the resident was returned from the hospital. The accident that required hospitalization occurred on and required medical attention for the " from her head " .
A record review of the facility's communication log on to does not mention that Resident # 11 on . There is a mention on on the communication log that the resident is " still out " . Records for the resident

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A 025	Continued From page 8	A 025		

reveal on the health assessment (AHCA form 1823) that the resident has a " gait disturbance " and " [illegible] " . The health assessment notes that the resident needs assistance with ambulation, toileting and transfer. The record does not clearly show the needs of the resident for the assistance with toileting. It was noted on the incident report that the resident was in the a bedside commode and a wheelchair. It was noted on the incident report for Resident #8 that the 2 staff " couldn ' t avoid her falling with the wheelchair in the way " . The only documentation about the resident was a move in note on / that indicates the resident is " wheelchair bound " and " legally " . It is noted that the husband assist with ambulation. The next note on the resident is on stating that the resident " last month while being assisted to use the toilet " . There is no documentation of the needs of resident #11 found in the chart. By not documenting the needs of the resident it is unclear if the accident could have been avoided with nursing or interventions.

An interview with the registered nurse on at approximately 3:00 pm, the registered nurse stated that the resident would insist on being transferred a certain way for toileting. The transfer the staff used on , which resulted in a with a hip, was the way the resident wanted to be transferred. The registered nurse stated that this was not a way she should have been transferred, for safety.

A record review revealed that Resident's #8, #9, and #11 should have had documentation the in their records according to the Prevention Policy for Langdon Hall. The Prevention Policy states that " any resident who will be assessed for injury and have a assessment initiated " . The policy also states that " all

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A 025	Continued From page 9 interventions are documented in the resident ' s health service plan " . Procedure includes " immediately contact the Health Care Director for assessment. If the Health care director is unavailable, then contact the Administrator, or the Manager on duty. Number 1 of the Procedures of the policy states that " a assessment is completed for each resident upon move in and during reassessment " . None of the residents had a assessment completed.	A 025		
A 055	58A-5.0185(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises; or in their or apartments, which must be kept locked when residents are absent, unless the medication is in a secure place within the or apartments or in some other secure place which is out of sight of other residents. However, both prescription and over-the-counter medications for residents shall be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility shall maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in	A 055		

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A 055	Continued From page 10	A 055		

a safe manner as described in this paragraph;
5. The facility determines that because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents; or
6. The facility ' s rules and regulations require central storage of medication and that policy has been provided to the resident prior to admission as required under Rule 58A-5.0181, F.A.C.
(b) Centrally stored medications must be:
1. Kept in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times;
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration shall be refrigerated. Refrigerated medications shall be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which refrigerator is located locked;
3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration, or administering medication. Such staff must have ready access to keys to the medication storage areas at all times; and
4. Kept separately from the medications of other residents and properly closed or sealed.
(c) Medication which has been discontinued but which has not expired shall be returned to the resident or the resident ' s representative, as appropriate, or may be centrally stored by the facility for future resident use by the resident at the resident ' s request. If centrally stored by the facility, it shall be stored separately from medication in current use, and the area in which it is stored shall be marked " discontinued medication. " Such medication may be reused if re-prescribed by the resident ' s health care

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A 055	Continued From page 11 provider. (d) When a resident ' s stay in the facility has ended, the administrator shall return all medications to the resident, the resident ' s family, or the resident ' s guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident ' s medications are still at the facility, the medications shall be considered abandoned and may disposed of in accordance with paragraph (e). (e) Medications which have been abandoned or which have expired must be disposed of within 30 days of being determined abandoned or expired and disposition shall be documented in the resident ' s record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (f) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations, record review and interview the facility failed to ensure medications were properly stored for 2 of 11 (#8, 9) sampled residents. Leaving the medications at beside for a resident that cannot properly self-administer the medications places the residents at risk of medication errors, which could lead to harm. Findings include: Observations of resident #8 at approximately 4:00 pm on found the resident to have medications at his bedside including , , , and . There was a dresser in the had a pill organizer with pills filled on some days and not others. The pills were not the same in each	A 055		

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compartment. There were pills missing on some of the days and not others. The resident stated that he was not using the pills in the pill organizer and he was not sure who put the pills in there. Also found on the dresser was an , , , in a pack. The medication was labeled to be taken four times a day of for 7 days, filled on . Nine of the 28 pills for the were missing from the pack. The , was not taken as ordered. Observations on at approximately 10:00 am found the resident in his in bed. The resident ' s equipped with a shower chair, raised toilet and rolling walker for the resident to use. The resident had a on that resulted in being transferred to the hospital for stiches. The resident also had a sometime the week of the survey, date unknown, and was not documented. The the week of the survey resulted in a to the top of the head, which required home health to come out and assess. assessments and dressing changes stated on . During the of resident #8 on , with the facility ' s registered nurse present, resident #8 was interviewed. The resident stated that he " so much that he can ' t keep track of them " . When asked about his medications the resident stated he is " so mixed up doesn ' t know if he is coming or going " . Resident #8 states he is taking medications for , , , and iron. All these medications are in the . Some of the pills are cuts in half. There are 7 bottles in the basket next to the bed and 5 bottles on the table next to the bed. Resident #8 stated that someone brought the pill box on the dresser and he thinks it was " not helpful " . When asked why he did not complete the he stated that he did not think that the was helping, so he

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(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 055	Continued From page 13 stopped taking them. A record review of Resident #8's chart found that the resident was assessed on to be able to self-administer his own medications. The resident had a medication observation record that included , , , , and . The and were not listed on the medication observation record. At the time of the observations on the registered nurse stated that she did not think he could properly take his own medications. Observations of Resident #9 with the registered nurse on at approximately 10:30, found the resident had medications at bedside. The medications found at bedside were Nystop (, power), and a . The over the counter medications were not marked with the resident ' s name. The Nystop was a prescription medication. The and were in containers that would have been purchased over the counter. When asked about the medications she was not sure where they came from. The registered nurse was present at the time of the observation. The registered nurse stated that she or someone must have purchased them for her. When the resident was interviewed regarding the medication she could not remember. A record review of Resident #9 revealed the resident has a history of and . The resident is not ambulatory per the health assessment. The resident did not have the or the listed on the medication observation record. The resident had not been assessed to be able to administer her own medication. The medication assistance policy for Langdon Hall states that " Medications are stored in the Health Care Office in a locked cabinet. Each resident ' s medications are stored	A 055		

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	AL11966444	A. BUILDING _____ B. WING _____	

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A 055	Continued From page 14 separately " . Resident #8 did not have medications stored in a way that he would be able to safely self-administer the medications as ordered. The medications for resident #9 were not properly stored according to the facilities policy and could have potential harmful effects for the resident.	A 055		
A 078	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Newly hired staff shall have 30 days to submit a statement from a health care provider, based on a examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable including . Freedom from must be documented on an annual basis. A person with a positive test must submit a health care provider ' s statement that the person does not constitute a risk of communicating . Newly hired staff does not include an employee transferring from one facility to another that is under the same management or ownership, without a break in service. If any staff member is later found to have, or is suspected of having, a communicable , he/she shall be removed from duties until the administrator determines that such condition no longer exists. (b) All staff shall be assigned duties consistent with his/her level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff shall exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident ' s record, and to report the observations	A 078		

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A 078	Continued From page 15 to the resident ' s health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of Rule 58A-5.0191, F.A.C. (d) Staff provided by a staffing agency or employed by a business entity contracting to provide direct or indirect services to residents must be qualified for the position in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor shall specifically describe the services the staffing agency or contractor will be providing to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility shall: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and 2. Maintain time sheets for all staff. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to have the appropriate screening for one of three staff members sampled, Staff B. By failing to maintain that current staff is free from and other communicable , the residents are placed at risk of contracting communicable from direct care staff. Findings Include: An interview on at 9:20 am with the business office manager it was found that one of three staff, Staff B, did not have a current and communicable screening. Record review revealed that Staff B was last screened for on and the box that shows the staff is free from communicable is not checked by the nurse practitioner signing off. The business office manager stated that she was not aware her	A 078		

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A 078	Continued From page 16 screening was not current.	A 078		
A 165	429.23 FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, " adverse incident " means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. [illegible]; 2. [illegible] or spinal damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places	A 165		

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A 165	Continued From page 17	A 165		

the resident at risk of harm or injury.
(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident.
(4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident.
(6) , neglect, or . must be reported to the Department of Children and Family Services as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a

Agency for Health Care Administration

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A 165	Continued From page 18	A 165		

licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.
(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.
(10) The Department of Elderly Affairs may adopt rules necessary to administer this section.

Adverse Incident Report.
(1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within one (1) business day after the incident on AHCA Form 3180-1024, Assisted Living Facility Initial Adverse Incident Report-1 Day, 2006, and incorporated by reference. The form shall be submitted via electronic mail to riskmgmtps@ahca.myflorida.com; on-line at http://ahca.myflorida.com/reporting/index.shtml; by facsimile to (850)922-2217; or by U.S. Mail to AHCA, Florida Center for Health Information and Policy Analysis, 2727 Mahan Drive, Mail Stop 16, Tallahassee, Florida 32308-5403, telephone (850)412-3731. AHCA Form 3180-1024 is available from the Florida Center for Health Information and Policy Analysis at the address stated above. The Initial Adverse Incident Report is in addition to, and does not replace, other reporting requirements specified in Florida Statutes.
(2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported under subsection (1) above, the facility shall submit a full report within fifteen (15) days of the incident. The full report shall be submitted on AHCA Form

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A 165	Continued From page 19 3180-1025, Assisted Living Facility Full Adverse Incident Report-15 Day, dated 2006, and incorporated by reference. The methods for obtaining and submitting the form are set forth in subsection (1) of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to file the 1 day and 15 day reports for adverse incidents for 1 of 11 sampled residents, Resident #11. Resident #11 had an adverse incident on . The adverse incident was a hip that required hospitalization. Findings include: A record review and interview, for Resident #11, revealed the resident on .Review of hospital records revealed the resident was treated for a of the right hip related to the . The resident was not able to return to the facility following the hospitalization and was transferred to a higher level of care. Interview with the administrator and registered nurse on at approximately 3:30 pm revealed that Department of Children and families (DCF) came to investigate about a month ago. The facility stated they did not have record that DCF had completed their investigation. The registered nurse stated that she tried to do a 1 day and 15 day report, but there was not documentation that the facility attempted the submissions. The administrator stated that he tried to submit a report, but did not have record of the attempt of the submission. The administrator acknowledges that the report was never submitted for the adverse incident of hip for resident #11. A record review of the Reportable Events Policy	A 165		

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A 165	Continued From page 20 and procedure for Langdon Hall states that the facility shall complete a 1 day incident report and submit to AHCA immediately or within 24 hours of the incident. Included on the incidents to be reported are " facture or of bones or joints " . Other record review included the Incident Reports Policy for Langdon Hall states " an incident report shall be used to report and incident, situation, or unusual occurrence that involved potential injury or harm to a resident, visitor or staff member. "	A 165		
AZ821	59A-35.110, FS Reporting Requirements; Electronic Submission (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal, (b) Bond renewal, (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider, (d) Annual sanitation inspections, (e) Fire inspections, (f) Approval of revisions to emergency management plans. (2) Electronic submission of information. (a) The following required information must be reported through the Agency ' s Internet site at http://www.ahca.myflorida.com/reporting/index.shtml: 1. Nursing homes:	AZ821		

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AZ821	Continued From page 21	AZ821		

a. Semi-annual staffing ratios required pursuant to Section 400.141(1)(o), F.S., and Rule 59A-4.103, F.A.C.
b. Adverse incident reports required pursuant to Sections 400.147(7) and (8), F.S., and Rule 59A-4.123, F.A.C.
c. Liability claim reports required pursuant to Section 400.147(10), F.S., and Rule 59A-4.123, F.A.C.
2. Assisted living facilities:
a. Adverse incident reports required pursuant to Sections 429.23(3) and (4), F.S., and Rule 58A-5.0241, F.A.C.
b. Liability claim reports required pursuant to Section 429.23(5), F.S., and Rule 58A-5.0242, F.A.C.
(b) The licensee must retain the receipt issued from the Internet site indicating that their transaction was accepted.
(c) If the Agency ' s Internet site is temporarily out of service, the required reports may be submitted by mail or facsimile as follows:
1. Semi-annual staffing ratios and liability claim reports are sent to the Agency for Health Care Administration, Central Systems Management Unit, 2727 Mahan Drive, 47, Tallahassee, FL 32308 or facsimile to (850)487-0470.
2. Adverse incident reports are sent to the Agency for Health Care Administration, Florida Center for Health Information and Policy Analysis, 2727 Mahan Drive, 16, Tallahassee, FL 32308 or facsimile to (850)922-2217.

This Statute or Rule is not met as evidenced by:
Based on record review and interview the facility failed to file the electronic report for 1 of 11 sampled residents, Resident #11. Resident #11 had an adverse incident on . The adverse incident was a hip that required hospitalization.

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AZ821	Continued From page 22 Findings include: A record review and interview, for Resident #11, revealed the resident on . Review of hospital records revealed the resident was treated for a of the right hip related to the . The resident was not able to return to the facility following the hospitalization and was transferred to a higher level of care. An interview with the administrator and registered nurse on at approximately 3:30 pm revealed that Department of Children and families (DCF) came to investigate about a month ago. The facility stated they did not have record that DCF had completed their investigation. The registered nurse stated that she tried to do a 1 day and 15 day report, but there was not documentation that the facility attempted the submissions. The administrator stated that he tried to submit a report, but did not have record of the attempt of the submission. The administrator acknowledges that the report was never submitted for the adverse incident of hip for resident #11. A record review of the Reportable Events Policy and procedure for Langdon Hall states that the facility shall complete a 1 day incident report and submit to AHCA immediately or within 24 hours of the incident. Included on the incidents to be reported are " facture or of bones or joints " . Other record review included the Incident Reports Policy for Langdon Hall states " an incident report shall be used to report and incident, situation, or unusual occurrence that involved potential injury or harm to a resident, visitor or staff member. "	AZ821		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Langdon Hall, Inc Independent & Assisted Living
1120 33 Avenue West
Bradenton, FL 34205

Dear Administrator:

Re: **CCR# 2012011660**

This letter reports the findings of a complaint survey that was conducted on 6-7, 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

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
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