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
	AL11967795	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGUILLA CAY SENIOR LIVING	1021 NORTH RIDGE ROAD LANTANA, FL 33462

(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 complaint survey (CCR # 2012013502.) was conducted on [redacted] Anguilla Cay ALF, had licensure deficiencies found at the time of the visit.	A 000		
A 027	58A-5.0182(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to needed health care, the facility shall, as needed by each resident: (a) Assist residents in making appointments and remind residents about scheduled appointments for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation for persons with [redacted] (c) The facility may not require residents to see a health care provider. This Statute or Rule is not met as evidenced by: Based on record review, interview and observation, it was determined the facility failed to provide assistance and supervision with Activities of Daily Living (ADLs) as physician order, for 1 out of 6 sampled residents (Resident #6). The findings are: Review of Resident #6's record indicated that she was admitted to the facility on [redacted] with diagnoses including [redacted]	A 027		

AHCA Form 3020-0001

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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A 027	Continued From page 1 and Review of the resident's health assessment dated on documented that she required assistance with ambulation, bathing and dressing, supervision with toileting and transferring and was independent with eating and . Review of the resident's service plan completed by the facility dated indicated that she only required verbal reminders for ambulation with own walker, bathing and toileting, and did not require any assistance with dressing. Review of the resident's physician orders dated indicated that the resident needed an x-ray evaluation due to persistent left hip pain. She also received a physical evaluation on with subsequent rehabilitation treatments for her left hip . Further review of the resident's record indicated that on she received an x-ray of her left hip due to a , which yielded no and she was transferred to the hospital on due to excessive in the stool. During an interview with Resident #6 at 9:40 AM in the hospital's she stated that for the past few months, she used to get around in the facility independently in a wheelchair provided by the facility because walking was painful to her hip. It was also revealed she received regular physical treatments to improve her mobility and was frustrated about her dependent condition since she was used to being independent. The resident also stated she did not receive consistent assistance while ambulating or transferring while in the facility for the past few months. In an interview with the Nurse Supervisor at 12:45 PM, she stated that Resident #6 ' s service plan	A 027		

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A 027	Continued From page 2 dated on is considered her plan of care and was followed by the facility staff. She stated at this time, that the resident was not physically assisted by facility staff with ambulation, bathing or (with dressing), since the service plan indicated that the resident only needed verbal cuing with those ADLs. The Nurse also stated at this time that she understood that the resident ' s health assessment dated was accurate and reflected the resident's actual condition and functional status, which required her to be assisted and supervised with certain ADLs. She also confirmed that the facility failed to provide the level of care for Resident #6 as documented by the resident's physican (as noted on the health assessment). Class III	A 027		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Anguilla Cay Senior Living
1021 North Ridge Road
Lantana, FL 33462

Re: CCR #2012013502

Dear Administrator:

This letter reports the findings of a complaint 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 , **2013** 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,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure

XG90

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5150 Linton Boulevard, Suite 500
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