

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK EAST, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14555 SIMS ROAD DELRAY BEACH, FL 33484		
(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 inspection survey (CCR# 2012013036 & 2012011719) was conducted on Heritage Park East, had licensure deficiencies found at time of the visit. Deficient practice was identified at CCR#2012013036.	A 000			
A 025 SS=D	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication	A 025			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6999

Y7V711

If continuation sheet 1 of 2

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A 025	Continued From page 1 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, it was determined the facility failed to provide care and services per physician orders, for 1 out of 5 sampled residents (Resident #2). The findings include: Observations during the tour on _____ at 9:00AM of Resident #2 sitting in the common area in a wheelchair revealed she had a heavily brown stained bandage on her right leg (not dated). A review of the resident's record revealed a physician's order dated _____ for home health dressing changes to the _____ on the right leg. During an interview on _____ at 11:10AM with the unit Nurse, the resident's home health file/folder was requested for review. The Nurse stated the resident does not have a home health folder because the resident had not been seen by a home health agency. The Nurse was unable to determine who placed the bandage on the resident's right leg and the exact date. She was also unable to provide documentation or an explanation as to why the facility failed to ensure the physician's order for home health and dressing changes were not provided to Resident #2. Class III	A 025			



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Heritage Park East, LLC
14555 Sims Road
Delray Beach, FL 33484

RE: CCR #2012011719 & CCR #2012013036

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2013 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 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/ls
Enclosure

