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
	AL11912046	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVEWELL AT CORAL PLAZA	5850 MARGATE BLVD. MARGATE, FL 33063

(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 (CCR# 2013000401, CCR# 2013000640 and CCR# 2013001065) was conducted on Livewell at Coral Plaza, had licensure deficiencies found at the time of the visit. Deficient practice was identified at CCR #2013000401 (A 0052) and CCR #2013000640 (A 0025). Please note deficient practice for CCR#2013000401 was cited under the Change of Ownership survey, as an uncorrected deficiency. (This survey was conducted in conjunction with the Change of Ownership revisit survey. Reference the separate report)	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	A 025		

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A 025	Continued From page 1	A 025		

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 Assisted Living Facility (ALF) failed to ensure resident records accurately reflected their conditions for 3 out of 3 sampled residents (Resident #1, #2 and #9), as evidenced by failing to document an assessment of wounds for residents #1, #2 and #9; and failed to provide adequate supervision for 1 out of 5 sampled residents (Resident #7) by allowing use of a loose knotted rope for bed mobility.

The findings include:

1) Resident #1 was admitted to the facility on : with a diagnosis of abnormal gait and . Review of the Resident's record revealed she was awake, alert and oriented x 3. During the initial facility tour on at 9:30 AM, Resident #1 was observed outside of her the second floor in a motorized scooter. Observation was made of a dressing to the outer aspect of her left lower leg. An interview was conducted with Resident #1 at 9:30 AM on . and she stated she sustained a to her left leg due to striking her leg on a broken side rail. An inquiry was made as to who was

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A 025	Continued From page 2	A 025		

doing the [illegible] care and she stated the nurses in the nursing station are doing it.

Review of the Wellness Record Notes reveal documentation on [illegible] and [illegible] with no evidence of documentation regarding a [illegible] or any other assessment of the resident related to the incident that caused the resident to sustain a [illegible]. On [illegible] at 2:53 PM an interview was conducted with the Director of Nurses (DON), who stated an incident report was completed after the resident sustained the [illegible] However, she confirmed there was no documentation in the resident's record regarding the incident, assessment of the resident or treatment rendered for the resident. The DON produced an incident report dated [illegible] documenting the resident has a [illegible] on her leg that she got while she was trying to go to bed and cut her leg on the bed. Documentation states maintenance was notified and they will fix the bed. Additionally, home health will follow up. On [illegible] at 3:00 PM, a request was made to the DON to review the home health agency chart for Resident #1. However, she was unable to produce the chart, stating the home health nurse might have taken it with her. The DON concurred that there should have been something documented in the resident's record regarding the [illegible] incident, assessment and treatment.

2) Resident #2 was admitted to the facility on [illegible] with diagnoses to include [illegible] accident and [illegible]. Review of the resident's record revealed Wellness Notes dated [illegible] the resident was started on [illegible] for [illegible] of the left foot and [illegible] care for the left second toe by the onsite [illegible] care. Further review of the record

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A 025	Continued From page 3	A 025		

revealed documentation on ... with no reference to the resident's left foot. The Wellness Notes dated ... document "Large amount of ... noted in sock of right foot. Upon inspection entire right great toe nail found in sock. Right toe continues to ... and 911 was called and resident sent to the hospital." The resident returned to the facility on the same day ... On ...: documentation states the resident's toe continued to ... and she was sent back to the hospital and returned back to the facility on ... documenting orders were received for the left great toe not the right great toe. However, there are no times documented when she left the facility or when she returned. Documentation dated ... states, ... care continues with home health to right great toe and left 2nd and 3rd toes." There is no evidence of documentation of any ... to the right foot or a second ... to the left foot. Further review of the resident's record revealed from ... through ..., no evidence of documentation of an assessment or condition of the resident's left foot and status if the wounds had healed. Documentation on ... document the resident sustained a ... to the left lower arm however there is no documentation regarding the status of the resident's left foot. Review of the Medication Observation Record dated ...: documented, ... ointment, apply to affected areas daily for ... care" with instructions the ... care was to be done by home health. There is no evidence of documentation of which body part the ... ointment was to be applied to. Documentation on ... and ... reveal no evidence of documentation of the status of the resident's left foot, right great toe or ... to the left arm. On ... documentation states "bandage to left

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heel clean, dry and intact" with no evidence of documentation of the status of the ... to the resident's left arm or right great toe.
Documentation on ... documents, "Home Health nurse providing ... care to left heel", with no evidence of the status of the ...
Further review of the resident's record revealed from ... through ..., no documentation regarding the resident's left foot ... right great toe or left arm ... On ... the resident was sent to the hospital with difficulty breathing and remains out of the facility as of ... of the home health progress notes provided no documentation of the status of the resident's left foot, right great toe or left arm ...
On ... at 3:30 PM, an interview was conducted with the DON inquiring about the status of the resident's ... to the left foot; right great toe and ... to the left arm. The DON stated she does not know how the ... started because she did not start working at the facility until ... 2012. However, she was unable to provide a description, condition or assessment of the resident's left foot ... right great toe and left arm ... for ... 2012 or ... 2013.
3) Resident #9 was admitted to the facility on ... with a diagnosis of ... accident and left sided ... Upon entrance to the facility on ... at 9:10 AM, a request was made for a list of residents receiving home health services in the facility. Resident #9 was listed as receiving home health services for a right arm ... Review of the resident's record revealed no evidence of documentation regarding when the ... occurred. Further review of record notes dated ... document the resident was visited by the home health nurse. However, there is no documentation

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A 025	Continued From page 5 regarding the reason for the visit. Review of the Wellness Record Notes dated [redacted] through [redacted] revealed no evidence of documentation of the assessment, condition or status of the [redacted] to the right arm. On [redacted] at 4:14 PM, an interview was conducted with the DON, who stated the resident is still receiving [redacted] care to the right arm by the home health agency. However, she was not able to give a description or status of the [redacted]. Review of the home health agency chart revealed a start of care date of [redacted] for wounds to the right hand and right knee. There was no further evidence of documentation in the home health chart regarding what or where the resident's current [redacted]nd(s) are located. On [redacted] at 4:20 PM, the DON stated she went to see Resident #9 to determine the location of the [redacted]nd(s). However, she revealed the resident had just left the facility on a pass. 4) On [redacted] at 12:09 PM Resident #7's [redacted] #123 was observed with the Administrator and Assistant Administrator present. A cloth rope about four feet long was observed attached to the right side of the bed at the mid-section and foot of the bed and extended about halfway across the bed. It was about 1/2 inch thick and had double knots every six inches or so. Both the Administrator and Assistant Administrator stated, it was the first they knew of the rope. They acknowledged the rope represented a potential safety hazard and was not acceptable for use as care equipment. Resident #7 was interviewed on [redacted] at 12:30 PM and stated he used the rope to help him move around in bed and that he has had it for a while. In interviews conducted at 12:37 PM and 12:41 PM respectively, a Housekeeper and a Caregiver both stated they were familiar with the	A 025		

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A 025	Continued From page 6 rope; the resident uses it to get in and out of bed but did not know how long it had been there. In an interview conducted at 2:10 PM, Resident #7's family member stated the rope was used to help the resident in bed and estimated it had been there for about a month. Class III	A 025		

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Livewell At Coral Plaza
5850 Margate Blvd.
Margate, FL 33063

RE: CCR #2013001065, CCR #2013000640 & CCR #2013000401

Dear Administrator:

This letter reports the findings of complaint surveys that were conducted on 2013 by representatives 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 **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 representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

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