

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964231	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER NATURE'S EDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 699 N.W. AIROSO BLVD. PORT SAINT LUCIE, FL 34983		
(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 #2013003765) was conducted on Nature's Edge, had no licensure deficiency found at the time of the visit related to this complaint. However, an additional licensure deficiency was found at the time of the visit, unrelated to this complaint.	A 000			
A 010 SS=D	58A-5.0181(4) FAC Admissions - Continued Residency (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (e) of this subsection, criteria for continued residency in any licensed facility shall be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a face-to-face medical examination by a licensed health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule. The form must be completed in accordance with that paragraph. After the effective date of this rule, providers shall have up to 12 months to comply with this requirement. (a) The resident may be bedridden for up to 7 consecutive days. (b) A resident requiring care of a _____ pressure _____ may be retained provided that: 1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a _____ health care provider, or the resident contracts directly with a licensed home health agency or a nurse to provide care; 2. The condition is documented in the resident's s	A 010			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0999

ACY911

If continuation sheet 1 of 4

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A 010	Continued From page 1 record; and 3. If the resident ' s condition fails to improve within 30 days, as documented by a licensed health care provider, the resident shall be discharged from the facility. (c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to the services of a licensed hospice which coordinates and ensures the provision of any additional care and services that may be needed; 2. Continued residency is agreeable to the resident and the facility; 3. An interdisciplinary care plan is developed and implemented by a licensed hospice in consultation with the facility. Facility staff may provide any nursing service permitted under the facility ' s license and total help with the activities of daily living; and 4. Documentation of the requirements of this paragraph is maintained in the resident ' s file. (d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility. (e) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. (5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident ' s needs, as determined by the facility administrator or licensed health care provider, the resident shall be discharged in accordance with Section 429.28(1), F.S.	A 010			

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A 010	Continued From page 2 This Statute or Rule is not met as evidenced by: Based on observation, record review and an interview, the facility failed to ensure the health assessment (Form 1823) was completed every 3 years and upon a significant change for one of 3 sampled residents (R2); and, failed to ensure the assessment was completed upon a significant change for one of 3 sampled residents (R3). The findings include: On _____, the health assessments (Form 1823's) for R2 and R3 were reviewed and the following discrepancies were identified: a) R2's most recent health assessment on file was dated _____ more than 3 years prior to this date _____. Additionally, the resident was placed on hospice on _____ due to a decline in health, specifically, the resident was observed requiring assistance with eating in the restorative dining area at 12:15 PM on _____. The assessment indicated the resident was "independent" with eating and did not have hospice care documented. b) R3's most recent health assessment on file dated _____ indicated the resident was "independent" with eating. However, the resident was observed in the restorative dining area at 12:15 PM receiving prompts and assistance (food was cut up) by staff with her meal. During interview with the assistant administrator at 2:30 PM on _____, he acknowledged that the new assessment were due and that the facility was in the process of obtaining them.	A 010			

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A 010	Continued From page 3 Class III		A 010		



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Nature's Edge
699 N.W. Airoso Blvd.
Port Saint Lucie, FL 34983

RE: CCR #2013003765

Dear Administrator:

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

