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
	AL11967950	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARK CENTER OF BREVARD II	424 VERONICA AVE, NW PALM BAY, FL 32907

(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 conducted Assisted Living Facility complaint inspection CCR#2013002674. The complaint was substantiated. There were deficiencies found at the time of the visit.	A 000		
A 010	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 licensed 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 record; and	A 010		

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A 010	Continued From page 1 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 record review and interview the facility failed to discharge 1 of 3 sampled residents (#3) when her behaviors continued to escalate, they were unable to keep the resident safe, which eventually resulted in the resident sustaining a Findings: Resident record review for #3 revealed an Assisted Living Facility health assessment form (1823) dated that stated diagnoses of frequent , generalized type 2, chronic back pain, and memory loss. The resident required a rolling walker and contact guard assist, had unsteadiness, was able to ambulate 150 feet with stand by assistance, was alert and oriented x 2 with and needed safety precautions. The resident needed supervision eating and assistance with bathing, dressing, ambulation, transferring and toileting. Review of facility notes dated stated her right thumb was looking better than it was on Monday . We (the unlicensed staff) soaked her thumb every day in warm water and monitor it on a daily basis. Finger soaked in soaking aid) to soothe her. Had physician appointment on at 2:15 PM. Interview with Staff C on at approximately 4 PM who stated on when I came back to work #3's thumb was . The resident asked me to look at the thumb. It was and discolored. I called the administrator; she	A 010		

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A 010	Continued From page 3	A 010		

came in and observed it. Both family members came in on [redacted] and observed it and I called the family member and she came in to look at it. They thought it might have been the walker that caused it. They were trying to figure out how it happened. The resident stated a few days later she caught it in the family member's car door. The next day I called the physician's office to make an appointment as her thumb was [redacted] and discolored.

Review of physician visit notes revealed:
[redacted] History - brought in because of discoloration of her dominant right thumb nail. Is prone to getting up in the middle of the night and sometimes found on floor. Complains of joint pain, joint The right thumb is , it is tender to palpation and she has no ability to flex the joint. Sensation is slightly decreased, decreased range of motion and tenderness.
Assessment: right thumb.
Other health issues: [redacted] with history of multiple , behavioral disturbance, gait disturbance, and

Plan: the thumb was placed in a The need for orthopedic evaluation. This will be a slow 46 (sic should state 4-6) week recovery period it should be kept immobilized during that time. Consideration of the patient relocating to a more supervised setting is warranted. We will convey this message to family member.
Imaging Report right thumb: There is a faint lucency identified at the level of the base of the [redacted] phalanx that could represent a non-displaced [redacted] visit - closed unspecified phalanx/[redacted] hand, dressing change, [redacted] on arm

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A 010	Continued From page 4 visit with orthopedist - thumb injury a week ago. X-rays show base at the inter-pha joint with mild displacement and moderate comminution (crushed bone). to return in one month. Review of facility notes revealed: Physician order call office if there are any behavioral changes or mental status changes in living was ok, a little shaken up but fine resident getting out of bed, very unstable, and 911 called, resident had a wanted to stay in bed, hard to assist, lashed back and refused care occupational visit, trained staff on transferring resident physical today today very and on one occasion combative and yelling at a resident out of control, won't stay in bed at night and refused to return to bed, been going on for a week, yelling at another resident out of control again, family called, family came over and calmed her down demanding and had a vulgar streak, very unpleasant today and seemed very demented and put hand on staff and called her name, refused medications with no injury, she misused her walker would not let resident in her , she became upset and fought staff and bit Staff C on the arm. Administrator called at 5 PM, my arm was and black in blue very observed resident's right elbow area, small bump, seems to be going down	A 010		

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A 010	Continued From page 5 ... Staff C looked at her arm it looks well ... acting out ... on worst behavior today, she is beating up on the staff. Refusing to sit down or listen. She really is out of hand. Very ... today, very loud, would not listen, up 3 times in middle of night taking off her clothes ... refused ... on ..., on her right wrist, the bottom of the mesh in resident ... torn off. Was agitated wanted to go home. At 7:20 PM , family came to assist her getting up from the floor, threw her diapers on the floor and was cleaning the floor ... not , very disagreeable, would not do her ... sugar ... Acted out badly last night. She removed her mattress from the frame, stripped her bed, annoyed ... so badly she was forced to sleep in the guest ... Mad loud outburst at 3 am. She continued to rumble through her dresser drawer making alot of noise. She continued to walk around her until she ... at 8 AM she was on the floor in her . She was acting out badly, yelling, cursing and fighting. Staff B and C tried calming her down but it didn't seem to work, maybe 30 minutes later I asked her to take her medication while sitting on the floor. She agreed. Still trying to convince her to let us help her off the floor, she refused. Still cursing and talking out of head. Maybe 10 minutes later we were able to put a gait belt around her waist and helped her off the floor. She finally calmed down and was ok the remainder of the day, her right thumb is looking better than it was on Monday. We (the staff) soak her thumb everyday in warm water and monitor it on a daily basis. Physician appointment on , at 2:15 PM.	A 010		

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A 010	Continued From page 6 finger soaked in to soothe her. had physician appointment today she moved today There was no consistent documentation that the physician was informed of the resident's behavioral changes or mental status changes. The facility did not discharge the resident when her behaviors escalated, they were unable to keep the resident safe, which eventually resulted in the resident sustaining a . Interview with the administrator on at approximately 11:35 AM who stated resident #3 was no longer was appropriate for the facility, she was verbally aggressive and with staff and the other residents. The resident grabbed a resident and the staff intervened to get her to release the resident, and she bit Staff C. She was not suitable any longer to be here. The family was informed the day she bit Staff C, the family member came here to see for herself the bite. That happened about the beginning of . I alerted the physician of her behaviors. She saw the physician on . She had and was very and aggressive. She came in 2012 and we started talking about her behaviors in approximately 2012. I informed the family at that time that her behavior was not acceptable. Class III	A 010		
A 030	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY	A 030		

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A 030	Continued From page 7 PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of the Florida . . . . . Hotline " 1(800)96 or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents. (e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s . . . . . and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other	A 030		

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A 030	Continued From page 8	A 030		

administrative and housekeeping practices, schedules, and requirements.
(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.
(g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.
(h) Pursuant to Section 429.41, F.S., the use of physical . . . . . shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical . . . . . .

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment,

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A 030	Continued From page 9 free from [illegible] and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a [illegible] his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any	A 030		

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A 030	Continued From page 10 resident. (j) Access to adequate and appropriate health care consistent with established and recognized standards within the community. (k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to provide care and services that were consistent with accepted standards of practice and did not: 1. provide medical attention in a	A 030		

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A 030	Continued From page 11 timely manner to 1 of 3 sampled residents (#3) when she had a thumb and 2. The facility did not give a 45 day written notice of discharge to the resident or the resident's responsible pary for 1 of 3 sampled residents (#3). Findings: 1. Resident record review for #3 revealed an Assisted Living Facility health assessment form (1823) dated that stated diagnoses of frequent generalized type 2, chronic back pain, and memory loss. The resident required a rolling walker and contact guard assist, had unsteadiness, was able to ambulate 150 feet with stand by assistance, was alert and oriented x 2 with and needed safety precautions. The resident needed supervision eating and assistance with bathing, dressing, ambulation, transferring and toileting. Review of facility notes dated stated her right thumb was looking better than it was on Monday We (the unlicensed staff) soaked her thumb every day in warm water and monitor it on a daily basis. Finger soaked in soaking aid) to soothe her. Had physician appointment on at 2:15 PM. Interview with Staff C on at approximately 4 PM who stated on when I came back to work on #3's thumb was The resident asked me to look at the thumb. It was and discolored. I called the administrator; she came in and observed it. Both family members came in on and observed it and I called	A 030		

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A 030	Continued From page 12	A 030		

the family member and she came in to look at it. They thought it might have been the walker that caused it. They were trying to figure out how it happened. The resident stated a few days later she caught it in the family member's car door. The next day I called the physician's office to make an appointment as her thumb was [illegible] and discolored.

Review of physician visit notes revealed:
[illegible] History - brought in because of discoloration of her dominant right thumb nail. Is prone to getting up in the middle of the night and sometimes found on floor. Complains of joint pain, joint [illegible] The right thumb is [illegible], it is tender to palpation and she has no ability to flex the [illegible] joint. Sensation is slightly decreased, decreased range of motion and tenderness.
Assessment: [illegible] right thumb.
Other health issues: [illegible] with history of multiple [illegible], behavioral disturbance, gait disturbance, [illegible] and [illegible].

Plan: the thumb was placed in a [illegible] The need for orthopedic evaluation. This will be a slow 46 (sic should state 4-6) week recovery period it should be kept immobilized during that time. Consideration of the patient relocating to a more supervised setting is warranted. We will convey this message to family member.
[illegible] Imaging Report right thumb: There is a faint lucency identified at the level of the base of the [illegible] phalanx that could represent a non-displaced [illegible] visit - closed [illegible] unspecified phalanx/[illegible] hand, dressing change, [illegible] on arm
[illegible] visit with orthopedist - thumb injury a week ago. X-rays show [illegible] base

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A 030	Continued From page 13 at the inter-phi joint with mild displacement and moderate comminution (crushed bone). to return in one month. The facility did not provide medical attention to resident #3 in a timely manner when she sustained a Interview with the family member on at approximately 5:30 PM who stated she was informed about the finger injury on that it was black and blue and by Staff C. She went to the facility on and stated to the administrator lets take her to the emergency The administrator stated the resident's family physician sees walk-ins on She said ok. She thought the facility would take her to the physician. She called the facility on and asked what the physician said about the resident's thumb. Staff A stated she did not know anything about it, and stated she did not go to the physician. Interview with the administrator on at approximately 2:50 PM who stated, the finger was reported to me on around by Staff C. I came over and looked at it Staff C called the family member to let her know. The family member called me, she wanted me to be here and was on her way. The thumb was and discolored, she had movement and complained of some discomfort. The resident explained how it happened, she said she did not hurt herself at first. She told her family member her thumb got stuck in between the brakes and the handle. The family member stated it had happened before. I told her I would call the physician for an appointment. We got the appointment for I took her to the physician and it showed a line below the first bone.	A 030		

Agency for Health Care Administration

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	AL11967950	A. BUILDING: _____ B. WING _____	

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A 030	Continued From page 14 There was no documentation to indicate the physician was notified. 2. Interview with the administrator on [redacted] at approximately 11:35 AM who stated resident #3 was no longer was appropriate for the facility, she was verbally aggressive and [redacted] with staff and the other residents. The resident grabbed another resident and the staff intervened to get her to release the resident, and she bit Staff C. She was not suitable any longer to be here. The family was informed the day she bit Staff C, the family member came here to see for herself the bite. That happened about the beginning of [redacted] I alerted the physician of her behaviors. She saw the physician on [redacted]. She had [redacted] and was very [redacted] and aggressive. She came in [redacted] 2012 and we started talking about her behaviors in approximately [redacted] 2012. I informed the family at that time that her behavior was not acceptable. Further interview with the administrator on [redacted] at approximately 2:50 PM who stated she gave the family a verbal 30 day notice of discharge and the family decided to take the resident out quicker. Resident record review revealed there was no documentation to indicate the facility gave the resident a written 45 day notice of termination. Class II	A 030		
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	A 078		

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A 078	Continued From page 15 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 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	A 078		

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A 078	Continued From page 16	A 078		

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 observation and interview the facility failed to ensure unlicensed staff were assigned duties consistent with their level of education, training and preparation and experience and did not ensure a nurse administered and checked sugars for 1 of 3 sampled residents (#3).

Findings:

Resident record review for #3 revealed an Assisted Living Facility health assessment form (1823) dated that stated diagnoses of frequent generalized type 2, chronic back pain, and memory loss. The resident needed assistance with self-administration of medications.

Review of the 2013 Medication Observation Record (MOR) revealed the resident received:
Lantus 14 units at bedtime, the MOR was initialed by unlicensed staff on through

One touch sugar twice a day before meals in AM and PM, the sugars were documented on through AM, there were no initials in the box.

Interview on at approximately 3 PM with Staff B, unlicensed staff, who stated the resident was not able to check her sugar or give her

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A 078	Continued From page 17 own [redacted] at any time when she lived in the facility. Interview with Staff C, unlicensed staff, on [redacted] at approximately 4 PM who stated I would set up the needle and units of [redacted], give to the resident and would guide her hand for the [redacted] sugar checks for resident #3. Interview with the administrator on [redacted] at approximately 3:30 PM who did not indicate she was aware the unlicensed staff were administering [redacted] and checking [redacted] sugars for #3. Class III	A 078		
AZ827	408.812, FS Unlicensed Activity (1) A person or entity may not offer or advertise services that require licensure as defined by this part, authorizing statutes, or applicable rules to the public without obtaining a valid license from the agency. A licenseholder may not advertise or hold out to the public that he or she holds a license for other than that for which he or she actually holds the license. (2) The operation or maintenance of an unlicensed provider or the performance of any services that require licensure without proper licensure is a violation of this part and authorizing statutes. Unlicensed activity constitutes harm that materially affects the health, safety, and welfare of clients. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the unlicensed provider or the performance of any services in violation of this	AZ827		

Agency for Health Care Administration

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AZ827	Continued From page 18	AZ827		

part and authorizing statutes, until compliance with this part, authorizing statutes, and agency rules has been demonstrated to the satisfaction of the agency.

(3) It is unlawful for any person or entity to own, operate, or maintain an unlicensed provider. If after receiving notification from the agency, such person or entity fails to cease operation and apply for a license under this part and authorizing statutes, the person or entity shall be subject to penalties as prescribed by authorizing statutes and applicable rules. Each day of continued operation is a separate offense.

(4) Any person or entity that fails to cease operation after agency notification may be fined $1,000 for each day of noncompliance.

(5) When a controlling interest or licensee has an interest in more than one provider and fails to license a provider rendering services that require licensure, the agency may revoke all licenses and impose actions under s. 408.814 and a fine of $1,000 per day, unless otherwise specified by authorizing statutes, against each licensee until such time as the appropriate license is obtained for the unlicensed operation.

(6) In addition to granting injunctive relief pursuant to subsection (2), if the agency determines that a person or entity is operating or maintaining a provider without obtaining a license and determines that a condition exists that poses a threat to the health, safety, or welfare of a client of the provider, the person or entity is subject to the same actions and fines imposed against a licensee as specified in this part, authorizing statutes, and agency rules.

Agency for Health Care Administration

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AZ827	Continued From page 19	AZ827		

(7) Any person aware of the operation of an unlicensed provider must report that provider to the agency.

This Statute or Rule is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure they obtained a Limited Nursing Services license before performing the services for 2 of 3 sampled residents (#3).

Findings:

Review of the facility's posted license revealed a Standard Assisted Living License that expired on [redacted].

1. Tour of the facility on [redacted] at approximately 11:25 AM revealed resident #1 had an ankle brace on her right ankle and she stated it was hard to get on and off; the staff put the brace on in the AM and took it off in the PM. She stated she [redacted] her ankle about 3 months ago.

Resident record review for #1 revealed an Assisted Living Facility health assessment form (1823) dated [redacted] that stated diagnoses of Parkinson's, [redacted] and [redacted].

Record review revealed there was no documentation to review to indicate there was a physician's order to apply and remove the brace.

2. Resident record review for closed record #3 revealed an Assisted Living Facility health assessment form (1823) dated [redacted] that stated diagnoses of frequent [redacted] generalized [redacted] type 2, chronic back pain, and memory loss.

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AZ827	Continued From page 20 Review of physician orders dated 10/2 ... gradient compression stocking knee high 15-20 millimeters of mercury on in AM off in PM. Review of the March ... Medication Observation Record (MOR) stated, Gradient compression stockings, on in AM and off in PM. The MOR was initialed by the unlicensed staff on ... the AM. Review of facility notes, written by unlicensed staff revealed on 2/2 ... the resident's thumb was looking better than it looked on Monday (2/2 ... staff soaked her thumb every day in warm water and we monitor it on a daily basis. Also documented on 2/2 ... ent's finger soaked in Epsom ... soothe her. There was no documentation to indicate a physician order was obtained to soak the resident thumb. Interview with the administrator on 3/1 ... 2:50 PM , who stated the unlicensed staff was applying and removing ankle brace for #1 and stockings for #3. The finger was reported to me on around 2/2 ... Staff B. The thumb was swollen ... discolored, she had movement and complained of some discomfort. The resident explained how it happened, she said she did not hurt herself at first. She told her family member her thumb got stuck in between the brakes and the handle. She did not indicate she was aware the unlicensed staff was soaking the resident's finger. Unclassified	AZ827		

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Ark Center Of Brevard II
424 Veronica Ave, Nw
Palm Bay, FL 32907

Dear Administrator:

Re: CCR #2013002674

This letter reports the findings of a state licensure survey that was conducted on , 2013 by representative(s) 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 surveyor(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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