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
	AL11965650	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES-CARE PREMIER	**12981 SW 52ND STREET FORT LAUDERDALE, FL 33330**

(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# 2013003886) survey was conducted on . . . . . The Res-Care Premier , had deficiencies found at the time of the visit.	A 000		
A 025	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 administration, or other changes which resulted in the provision of additional services.	A 025		

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A 025	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to adequately provide care and services to meet the needs of residents that have limitations due to as evidenced by the failure to provide appropriate supervision to promote safety and physical and emotional well being, for 2 out of 3 sampled residents (Residents #2 and #3). The findings include: The facility admits residents that have injuries, and therefore the residents require 24 hour supervision and monitoring for their safety. The facility is located on a narrow unpopulated country road, adjacent to canals and a narrow bridge. The following was noted specifically during survey conducted on a) Resident #3 was admitted on . His medical conditions include right , and aphasia. The resident is non verbal and ambulatory. He requires assistance with all his ADL care. The 1823 Admission form reveals the resident requires daily oversight, and observation of his whereabouts and well being. b) Resident #2 was admitted on with medical diagnosis of old , dyslipidemia, , chronic , gait imbalance, and . He has visual / mobile limitations, an unsteady gait and poor safety awareness. He is independent for all ADL except for supervision for bathing and . He is and able to verbally	A 025		

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A 025	Continued From page 2	A 025		

respond with simple word answers. The health assessment (form 1823) reveals the resident needs daily oversight, observation of his whereabouts and well being. The resident is documented as refusing to use a wheelchair/walker for ambulation and supplemental for his
He has a documented history for on and . A facility Health Awareness Rating Tool dated reveals the resident requires highest support for walking, due to immobility issues. He requires lower support for safety ability, to report illness or injury to staff, ability to report neglect, or to staff, ability to follow emergency plans, evacuations, and ability to identify and report environmental hazards. On at approximately 11:15 AM the resident was observed with around his left eye. The resident stated he and hit his eye, but it did not hurt. The resident was observed ambulating to the transportation van, his gait was unsteady and stiff.
c) Record review of the facility's incident log revealed an incident report dated , at 8:53 PM, that Resident #2 had tripped on the living and . The report documents the staff evaluated the resident and found no . The report documents the resident's Case Manager and the Administrator were notified of the incident. The report does not document if the physician was notified.
On at approximately 2:00 PM during an interview with the Administrator, he stated that he had observed around the residents eye on the morning of . He stated he that he requested the direct care staff who was caring for the resident on to write another incident report documenting the No incident report could be found by the

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A 025	Continued From page 3	A 025		

Administrator.
d) Further review of incident reports revealed an incident on [redacted] at 8:30 PM, when Resident #2 and #3 were left at the facility unsupervised while the sole employee #3, brought Resident #1 to get ice cream at a Dairy Cream, as a scheduled community outing. The report documented that Residents #2 and #3 did not want to leave the facility so the employee made the decision to leave the residents unattended and unsupervised. Review of the report revealed the Administrator completed an incident report on [redacted] at 4:05 PM , he alerted his corporate supervisor and the [redacted] Hotline. The report does not indicate if he notified the residents family or legal guardian of the incident.
e) On [redacted] at approximately 9:45 AM, during an interview with the Administrator, he confirmed aforementioned incident had occurred on [redacted] He stated that Residents #2 and #3 did not sustain any injuries as a result of being left alone and unsupervised. He stated that he was alerted to the incident on [redacted] in the afternoon, when he inquired to Resident #2 how was the trip to the ice cream parlor. He stated that Resident #2 told him that he and Resident #3 did not go, but the employee and Resident #1 brought back ice cream for them. The Administrator stated that he immediately spoke with the employee to question what occurred. He stated that the employee told him that Residents #2 and #3 did not want to go get ice cream so he made the decision to leave the residents alone for [redacted] minutes, while he and Resident #1 went to get ice cream. The Administrator stated that he placed the employee on administrative leave pending an investigation and called the [redacted] hotline. He stated that the employee had a recent history of improper conduct related to supervision

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A 025	Continued From page 4	A 025		

of residents and following the facility policies and procedures. The Administrator stated that the employee had been terminated as a result of the incident and that all direct care staff were inserviced on for proper supervision of residents at all times. The Administrator confirmed that all the residents required supervision at all times.

f) On at 1:30 PM during an interview with the Administrator, he stated he informed the responsible parties about the incident but did not document it on the incident report. Further record review of the facility Progress Notes revealed, no documentation that the residents' responsible parties were notified about the incident. The Administrator provided documentation from the Department of Children and Families dated that there had been an investigation of the incident for both residents. He stated that the investigators had attempted to interview the residents and determined that no harm had occurred as a result of the lack of supervision.

g) Record review of the corrective action form dated documented that the Employee #3 left 2 residents (Residents #2 and #3) unattended and unsupervised while he and another resident went on a scheduled community outing. The report documented the reason for the action as an act of disrespect, and /or neglect towards the individuals served. The Employee was terminated.

Further review revealed on Employee #3 had failed to perform assigned tasks and training as per policy, by failure to sign off medications given to a resident on the Medication Observation Record. On the employee was counseled for failure to complete clients daily observation documentation as per facility policy. On 02/08, employee failed to complete documentation of the

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A 025	Continued From page 5	A 025		

residents' sleep log and the 3rd shift report as he was trained and per facility policy. And on , the employee failed to follow safety rules and health practices by failure to sign the control substance medication count sheet at the change of shift and failure to administer a scheduled medication to a resident.

h) Review of Employee #3, personnel record reveals he was hired on a full time status. He had a level 1 AHCA background screening completed on . The record documents he completed elopement training, emergency preparedness/ evacuation training, and had current /first aid training. The record contained documentation of the required Medication Assistance continuing education training conducted on but the required training time, 2 hours, was not recorded on the certificate. The employee had received Recognizing and Reporting Neglect and training on , but no required time was documented. There was no documentation of required Incident Reporting or Resident Rights training in his file.

On at approximately 1:00 PM the Administrator reviewed Employee #3's file and was unable to provide documentation that the employee received the required resident rights and incident reporting training. He was unable to provide documentation that the training for assistance with self-administered medication and recognizing and reporting and neglect had been completed and met the training time requirements.

Record review of Resident #3's record revealed on at 10 PM, " the resident went out with staff and group home residents for ice cream, the resident stayed with group. " During an interview with the Administrator on

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A 025	Continued From page 6	A 025		

at 1:45 PM, he reviewed the Progress Note and confirmed that the resident did not go out to get ice cream, he had stayed in the facility alone and unsupervised. The Administrator stated he was unaware that the employee had documented inaccurately.

i) On [redacted] at approximately 10:00 AM an interview was conducted with the Certified Nursing Assistant that cares for the residents, she stated that she had worked at the facility for 12 years. She stated that all residents were ambulatory but required monitoring to prevent injury. She stated that at no time should the residents be left unattended or unsupervised. She stated the residents needed to be monitored at all times.

j) Record review of the facility's Human Resources Policy and Practice Manual, "Standards of Conduct" policy, last revised [redacted] revealed " the facility maintains that certain rules and regulations regarding employee behavior are necessary for the efficient operation of the company and for the benefit and safety of all employees and persons served " . It states further "Any acts of disrespect, [redacted] and/ or neglect toward the individuals we serve will be a violation of the policy and subject to corrective action up to and including termination. "

k) On [redacted] at approximately 2:00 PM during an interview with the Administrator, he reviewed the policy and stated that the employee ' s decision to leave the residents unattended demonstrated poor safety judgement and therefore was grounds for termination. Also, the employee had previous corrective actions which further demonstrated noncompliance with facility

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A 025	Continued From page 7 policies. He stated that the residents are to be monitored and supervised for their safety at all times. Employee#3's failure to supervise Resident #2 and #3 on [redacted] (at 8:30 PM for 10 to 20 minutes) by leaving them unalone and unattended in the facility directly jeopardized and endangered the resident's safety and well-being on noted date. As evident of both residents requiring 24 hour care and supervision due to aforementioned medical diagnosis. Class II	A 025		

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Res-Care Premier
12981 SW 52nd Street
Fort Lauderdale, FL 33330

Dear Administrator:

Re: CCR #2013003886

This letter reports the findings of a state complaint survey that was conducted on 2013 by representatives 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 representatives. 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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