STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910091	09/05/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Lakeland	**2111 Lakeland Hills Blvd. Lakeland, FL 33805**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

Two unannounced complaint surveys, CCR# 2013007955 and CCR# 2013008023, were completed on [redacted].

The Emeritus at Lakeland, assisted living facility, had deficiencies at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on interviews and record reviews, the facility failed to ensure adequate supervision and care was provided for 5 (Residents #1, #2, #3, #4, and #5) of 5 residents sampled in a secured memory care unit.

Findings include:

Review of Residents #1's record revealed that his health assessment, Form 1823 dated [redacted] indicated that he was diagnosed with [redacted] and his needs could be met at an ALF. The resident's physician's examinations dated [redacted] revealed that the resident was examined and ordered care for aggressive and/or combative behavior.

Review of Resident #1's service notes revealed that facility staff failed to adequately supervise Resident #1's interaction with other residents even though they were aware of his aggressive behavior:
On [redacted], staff reported that Resident #1 and Resident #5 reported to staff that Resident #1 had hit Resident #5. Staff checked the resident and noted she had black and blue marks on her head.
Resident #1 had no injuries and was sent to the hospital for evaluation and treatment.
On [redacted], notes indicated that the doctor followed up with the resident due to increased reports from care staff that the resident was combative in the evenings. Order was received for [redacted] analysis with culture and sensitivity (UA with C&S - test for [redacted], which has been known to cause [redacted] in the elderly) and a [redacted] (psych) nurse through home health.
On [redacted], staff reported that on [redacted] Resident #1 was in Resident #4's [redacted] away when the staff entered the [redacted] Staff redirected the resident out of the [redacted] Resident #4 stated, "He grabbed my arms." No injury was noted by doctor. Other urinalysis and psych nurse services were ordered. Staff was to monitor.
On [redacted] staff reported on [redacted] that they heard screaming. When they entered Resident #3's [redacted] they stated Resident #1 had Resident #3's arm. The resident #3 stated Resident #1 had hit her. Staff reported that Resident #3 had a bump on her head. Resident #1 had no injury. Resident #1's doctor was called and the [redacted] (treats agitation) was increased to 10mg (was previously 5mg). Staff was to increase checks and redirect the resident.

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On , staff reported that Resident #1's left hand was and complained of pain. X-ray was ordered. (Home health notes dated speculated that the resident injured his hand during a combative episode with another resident 2 days prior.)
In Resident #1's service notes dated , staff reported that on he was observed in another resident's , on top of the resident, physically hitting the resident's head and pummeling on the bed. Resident #1 was sent to emergency (ER) for evaluation and treatment. Other resident was also sent.
Interview with the resident care director (RCD) on at approximately 5:15pm revealed that on in the dining . Resident #2 had grabbed Resident #1's food and Resident #1 slapped Resident #2 in the face. Staff changed the table where they ate and that resolved the issue.

Review of records for Residents #2, #3, #4, and #5 revealed there were no service notes or other facility documentation of these incidents involving Resident #1. There was also no facility documentation of calls made to family or doctors or any treatment received related to the incidents.
In the interview with the RCD on at approximately 5:35 p.m., she acknowledged the lack of documentation for the incidents in the residents' records.

The facility also failed to ensure that Resident #1 received recommended medical care. After discharge from the hospital following the incident involving Resident #5, Resident #1's Patient Instructions for Aftercare form dated revealed that the facility was to provide medical and psych followup within 5 days after discharge from the hospital.
Review of Resident #1's health assessment, Form 1823 dated listed on the first page, under the service requirements section, "medication management and home health care with psych followup."
Interview with the RCD on at approximately 3:45pm revealed that Resident #1 did not receive a psych consult with home health as indicated on his health assessment. There was no psych consult with home health after noted in the Home Health Client Coordination Notes Report. The RCD called and verified with the home health agency during the survey that the resident was not seen during that time by home health.

Class II

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on interviews and record reviews, the facility failed to ensure that all residents lived in a safe and -free environment for 4 (Residents #2, #3, #4, and #5) of 4 residents sampled.

Finding include:

In the interview with the memory care director (MCD) on at approximately 12:10pm, she stated that Resident #1 went into the wrong Resident #2's . She believed that Resident #2's alerted the staff that they were having a verbal confrontation and Resident #1 was the one that was combative. The staff did not witness the altercation. The , Resident #10 stated that Resident #1 was verbal and was hitting Resident #2. They were both sent out to the hospital, but other than back pain, she was unaware of injury.
Resident #1 was for medication management. Review of Resident #2's physician's notes dated from the hospital indicated that he was examined and released the same day. He had tender spots on

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his chest and pelvis. The x-ray showed no evidence of . He had a diagnosis of of the face.
In the interview with Staff A, a resident aide on , at approximately 4:50pm, she reported that Resident #1 went to Resident #2's . Resident #10 came out and said someone was beating up his . When they came in the , Resident #1 was on top of Resident #2, on his bed, pressing him down by his arms, but they did not see Resident #1 hit him. They directed him out the . The police came. Resident #2 stated his head hurt, but she could not see any physical injuries. He went out to hospital. They both went. She also reported another incident that involved Resident #1. He was wandering and went into Resident #3's ; they heard her scream and went in her . He had her by her arm and she had a bump on the side of her forehead. They did not witness him hit her, but she said he hit her. She went to the hospital.
In the interview with the resident care director (RCD) on , at approximately 5:15pm, she stated that whatever opened was the #1 went to. Staff saw Resident #1 had Resident #2 (whose hand was contracted from a previous on the bed. Staff stated he was punching him. Resident #1 was easily redirected by staff. He went to the hospital for medication management.
In the interview with Resident #2's , Resident #10 on at approximately 1:30pm, he stated that Resident #1 liked to hit people. He continued, telling how Resident #1 had tried to hit him but he ducked . He stated that the place would be better off without him; they need to get him out of the facility for good. The resident stated that Resident #1 went over to his and started punching him. He stated he ran out to the hall and got help from staff. He stated that his can't defend himself because he is .
Review of Resident #1's record revealed that he was admitted to the facility on . His health assessments, Forms 1823 done on , and all indicated that the resident had and he needs could be met at an ALF. In Resident #1's service notes dated , staff reported that on he was observed in another unidentified resident's , on top of the resident, physically hitting the resident's head and pummeling on the bed. Resident was sent to emergency (ER) for evaluation and treatment. Other unidentified resident was also sent.
Resident #1's other service notes indicated other aggressive incidents:
On , staff reported that Resident #1 and Resident #5 reported to staff that Resident #1 had hit Resident #5. Staff checked the resident and noted she had black and blue mark on her head. Resident #1 had no injuries. He was sent to the hospital for evaluation and treatment.
On , notes indicated that the doctor followed up with the resident due to increased reports from care staff that the resident was combative in the evenings. Order was received for analysis with culture and sensitivity (UA with C&S - test for , which has been known to cause in the elderly) and a (psych) nurse through home health.
On , staff reported that on Resident #1 was in Resident #4's away when the staff entered the . Staff redirected the resident out of the . Resident #4 stated, " He grabbed my arms. " No injury was noted by doctor. Other urinalysis and psych nurse service were ordered. Staff to monitor.
On , staff reported on that they heard screaming. When they entered Resident #3's , they stated Resident #1 had Resident #3's arm. The resident stated Resident #1 had hit her. Staff reported that Resident #3 had a bump on her head. Resident #1 had no injury. Resident #1's doctor was called and the (treats agitation) was increased to 10mg (was previously 5mg). Staff was to increase checks and redirect the resident.
In the interview with the memory care director on at approximately 12:10pm, she discussed the measures used to address the Resident #1's combative behavior. She stated that staff keep him in programming (activities) and put together kits and baskets, like sports, which are independent activities he can do in his . His pretty empty so they met with the family and brought in a TV and old tapes. They try to coax him into morning exercise. He goes to men's social, musicals and other activities that he likes. Staff requested family to bring in decals for the outside of his door so he recognizes his .
In the interview with the RCD on at approximately 4:00 p.m., she also discussed measures used to

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prevent or address the resident's potentially combative behavior. She stated that Resident #1 has a TV in his which keeps him more in his . He watches old black and white movies which his son said he used to do at home. He gets more into activities. He folds laundry, if he is up. He likes to sweep the front porch. If they notice that he wanders, they redirect him to his . the common area or some activity. The med tech is responsible to keep an eye on him while the other aides are doing activities. She stated that staff can't do one on one, but they keep more of a visual on him. Staff started to keep a visual eye on him before the incident with Resident #3. However, staff got distracted by a 911 call for another resident. One staff member stays at the door, one stays with the resident, the other staff member is calling the family and doing paperwork. They usually keep one staff person in the common area. Resident #1 has medication management and followup with the doctor. Staff keeps him occupied during 6pm to 11pm which was the period of time when he had the most incidents. The medication times for his were adjusted until a timeframe was found that worked the best. He also started taking
The facility staff was aware that Resident #1 had combative behavior. The preventive measures during the time of the episodes were ineffectual and did not protect the other residents.

Class II

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on interviews and record reviews, the facility failed to report an adverse incident for 3 (Residents # 1, #3, and #5) of 5 residents sampled in a secured memory care unit. Facility also failed to make a required report to a state agency of enacted by a resident for 4 (Residents #2, #3, #4, and #5) of 5 residents sampled in a secured memory unit.

Findings include:

Review of Resident #1's service notes revealed that on staff reported that Resident #1 and Resident #5 reported to staff that Resident #1 had hit Resident #5. Staff checked the resident and noted she had black and blue mark on her head. Resident #1 had no injuries. He was sent to the hospital for evaluation and treatment.
Review if Resident #1's service notes dated revealed that staff reported on that they heard screaming. When they entered Resident #3's they stated Resident #1 had Resident #3's arm. The resident stated Resident #1 had hit her. Staff reported that Resident #3 had a bump on her head. Resident #1 had no injury. Resident #1's doctor was called and the (treats agitation) was increased to 10mg (was previously 5mg). Staff was to increase checks and redirect the resident.
Review of Resident #3's record revealed Patient Instructions for Aftercare dated from the hospital for a visit related to a physical assault.
There were no documentation at the facility of these episodes being report as adverse incidents.
Interview with the resident care director (RCD) on at approximately 5:50pm revealed that she was not sure adverse incidents reports were done for these incidents.
In the phone interview with the RCD on at approximately 4:00pm, she reported that she submitted the adverse incidents reports for the episodes involving Resident #1 with Resident #3 or #5 that had not been submitted before the survey.

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Further review of Resident #1's service notes on revealed that staff reported that on Resident #1 was in Resident #4's away when the staff entered the Staff redirected the resident out of the Resident #4 stated, " He grabbed my arms. " No injury was noted by doctor. Other urinalysis and psych nurse service were ordered. Staff to monitor.
Review Resident #1's service notes dated , staff reported that on he was observed in another resident's on top of the resident, physically hitting the resident's head and pummeling on the bed. Resident was sent to emergency (ER) for evaluation and treatment. Other resident was also sent.
Phone interview with the RCD on at approximately 10:55am revealed that she did not know she needed to call the state agency to report She stated she would call that day.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Emeritus at Lakeland
2111 Lakeland Hills Blvd.
Lakeland, FL 33805

Dear Administrator:

Re: **CCR# 2013007955 & CCR# 2013008023**

This letter reports the findings of two complaint surveys that were conducted on 3-5, 2013, by representatives of this office.

Attached is the provider's copy of the State (5000-3547) 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 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 surveyors. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Paul Y Brown

For Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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