STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910053	10/08/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Grace Manor At Lake Morton, Llc	610 East Lime Street Lakeland, FL 33801	
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= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A complaint survey, CCR# 2013008974, was conducted on

The Grace Manor at Lake Morton, LLC, assisted living facility, had deficiencies at the time of the visit.

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

Based on record reviews and interviews, the facility failed to document changes in condition or major incidents for 1 (Residents #1) of 5 residents sampled for record review.

Findings include:

Phone interview with Staff A on at approximately 4:40pm revealed that on , Resident #1 complained of a like he had a hot rod in his eye. He later had then his was abnormally high, he lost his vision, and finally he was aspirating his After Resident #1's condition declined from about 10:30pm to 11:30pm to about 3:00am to 3:30am, he was finally sent to the hospital by ambulance.
Review of Resident #1's hospital **Emergency Department Note - Physician final report** dated revealed that he suffered a The hospital record revealed that he that same morning.
Record review for Resident #1 revealed that there was no documentation in his records regarding the event at the facility that preceded his hospitalization and
In the interview with the executive director on at approximately 2:20pm, she stated there was documentation for Resident #1 but it was missing after another government agency was given copies.
Review of the facility's medical emergencies policy on page 93 and 94 of the facility's assisted living policy and procedure manual revealed that a narrative chart entry is made in the resident's chart regarding the circumstances which led up to the call to emergency services, what care was provided by the staff, and the resident's response to the care.

Class III

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 a resident received appropriate medical

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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

care in a timely manner which led to continued pain and delayed medical care for 1 (Resident #1) of 5 residents sampled for record review.

Findings include:

In the phone interview with Staff A, a former med tech/caregiver on [redacted] at approximately 4:40pm, she stated that the last night that Resident #1 was sent to the hospital, Staff B (another caregiver) and she were working. They did their final rounds. Resident #1 came out about 10:30 - 11:30pm and complained about a [redacted] like a hot rod was in his eye. Staff A called the resident care coordinator (RCC) and told her what was going on. She asked the RCC if she could give him a brand name medication for [redacted] that he had scheduled for later in the morning. The RCC said Staff A wasn't supposed to but she could just this one time. Staff A stated Resident #1 was hurting. She could tell he was in pain by his demeanor. About 11:30am to 12:30am, he started [redacted] when he was in the recliner. He was in the recliner so they could keep an eye on him. She called the RCC again and she said just keep an eye on him and she would deal with him in the morning. The RCC told Staff A that she knew the family would be upset if they sent him out because he had done this thing before. At 12:30am to 1:30am, it got worse and his breathing got worse. He was breathing funny. His vitals were going crazy. His [redacted] was 200 and something over 100 and something. His pulse was fast and [redacted] saturation was low. His breathing was irregular. She called the RCC again and she said to call the home health company. The guy she spoke to at home health asked why does he need to come and she explained the situation and the vitals. He stated based on Resident #1's vitals he should be sent out to the hospital. She called the RCC again and told her what home health said and the RCC said " no ", to not send him out and she would deal with him in the morning. At 1:30am to 2:30am, he was panic screaming (like yelling). He said now I know what it feels like to die alone. He already had problems with his left eye and it was white and he could not see out of it, but he could see out of his right eye. However, then he complained that he could not see them and they were right in front of him. She called the RCC again and she responded again that she would deal with him in the morning. At 3:30am, he was puking but she could hear it gurgling back in his lungs. He was aspirating. She called the RCC and told her that she was sending this man out even if she had to be written up. He was throwing up and now he is aspirating. She stated OK do whatever you have to do. EMTs (emergency medical technicians) got there about 3:45am. They go to move him onto the stretcher. He can't stand. He had a [redacted] Emergency medical services [redacted] and the emergency [redacted] asked her why the resident was not sent to the hospital earlier. A friend who worked at the facility told her the next day Resident #1 [redacted] at 6:45am.

Phone interview with Staff B, a med tech/caregiver was conducted on [redacted] at approximately 5:40am. She reported that on the night of the incident at 11pm, Resident #1 complained that his eye hurt and he had a bad [redacted] Staff A called the RCC and she said to go ahead and give the brand name medication for [redacted] he had scheduled at some point during the next morning. In an hour, he stated it was getting worse. Staff A called the RCC and she stated he did this before and to keep an eye on him. They sat with Resident #1 throughout the night in the living [redacted] front. Resident #1 would freak out if he could not see them. He stated he could not see them and they were right in front of his face. He said to please not leave him because he did not want to die alone. Staff A called again and finally got permission to call 911 from the RCC about 2 am to 3 am. Paramedics asked if leaning to the side was normal for him and they told them it was not normal. They asked if his face drooping was normal and they said, " no. " They did a stress test and he was weaker on one side. He [redacted] to the side when they stood him up and stated they think he had a st[redacted] when they took him out on a stretcher. Staff B stated she felt like Resident #1 should have went out to the hospital the first time Staff A called the RCC. Resident #1 stated he felt like a hot rod was stabbing through his eye. It was not normal for him to come out of his [redacted] complain of pain.

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In the interview with the RCC about Resident #1 on [redacted] at approximately 2:15pm, she stated that Staff A called her once for Resident #1's [redacted] and she asked Staff A if he had anything she could give him for pain and Staff A said a brand name medication for [redacted]. The RCC said, " well give him that. " Staff A called back later and stated he was throwing up and she told Staff A to send him to the hospital. It started about 1 am and she did not know how long in between before Staff A called the second time. She stated she did not remember exact times because it happened almost a year ago.

The [redacted] report dated [redacted] indicated that the [redacted] alert was called at 3:28am and Resident #1 arrived at the hospital at 3:43am.

The hospital Emergency Department Note - Physician final report dated [redacted] noted that the physician spoke directly to the staff at the facility and was told that at 11pm or so Resident #1 had severe pain behind his right eye. He walked out to the nursing station to request help. Resident #1 sat down in a chair near the nursing station and stayed there for the next few hours. Somewhere between 3 and 3:15am, Resident #1 became less responsive and [redacted] and developed slurred speech. Facility staff did not notice left sided [redacted]. At the hospital, Resident #1 was diagnosed with [redacted] (a type of [redacted] where an [redacted] bursts in the [redacted] and causes [redacted] in the [redacted].
The hospital [redacted] record indicated that the resident passed at 7:25am on [redacted].

Interview with the RCC on [redacted] at approximately 2:40pm revealed that the staff let them know if residents are sick and then they contact the nurse (a home health nurse because the facility has no nurses) and she comes to evaluate. If the nurse states they need to go out to hospital, then they send them. If it ' s nighttime, staff call her (the RCC) and then the nurse is called and the nurse still comes to assess. They send the resident out if the nurse says so. Sometimes a consult with the nurse is done on the phone and the nurse might say to go ahead and send out.

Interview with the executive director (ED) revealed that Resident #1 ' s family was adamant about not sending him out to the hospital (not specifically talking about this event, but previous ones).
Review of the hospital Emergency Department Note - Nursing final report dated [redacted] revealed that [redacted] reported that the family was not thrilled with the idea of the resident being transported to the hospital.

The facility ' s medical emergencies policy was located on page 93 and 94 of the facility's Assisted Living Policy and Procedure Manual. Section 1 indicated that the administrator should be contacted immediately and section 2 indicated that the administrator makes the determination of the severity of the situation. Section 3 indicated that the community summons emergency medical services by calling 911, when the resident exhibits signs and symptoms of distress and /or emergency condition. One example included was sudden onset of severe pain. Resident #1 had indicated to staff that he felt like a hot rod was stabbing through his eye, but medical care was still delayed for hours.

Class II

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910053	10/08/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
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0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC
Based on interview and record reviews, the facility failed to ensure that all residents residing in a secured memory care unit who are at risk of elopement have identification on their persons that includes the resident's name and the facility's information, such as name, address and telephone number.

Findings include:

Interview with the executive director (ED) on [redacted] at approximately 9:45am revealed that Resident #2 had eloped from the facility.
Review of the adverse incident report for Resident #2 revealed that she had eloped from the facility on [redacted]. She was brought back to the facility by the police.
Continued interview with the ED on [redacted] at approximately 9:45am revealed that Resident #2 did not have any identification on her when she was found. The resident told the police her name and they called her daughter. The daughter told them the name of the facility in which the resident lived. The ED stated that none of the residents at the facility had any identification (ID) on them.
Review of an order receipt provide by the ED revealed that she purchased ID bracelets for the residents the same day of the survey.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on record review and interviews, the facility failed to ensure proper assistance with self-administration of medications as ordered for 1 (Resident #1) of 4 residents sampled for medication review.

Findings include:

In the interview with the resident care coordinator (RCC) on [redacted] at approximately 2:15pm, she stated that Staff A, a medication technician called her once for Resident #1's [redacted] and she asked Staff A if he had anything she could give him for pain and Staff A said a brand name medication for [redacted]. The RCC said, " well give him that. " She stated that this occurred at about 1:00am.
Phone interview with Staff A on [redacted] at approximately 4:40pm revealed that she called the RCC between 10:30pm to 11:30pm because Resident #1 was complaining of a [redacted] like a hot rod was in his eye. Staff A asked the RCC if she could give him a brand name medication for [redacted] that he had scheduled for later in the morning. The RCC said Staff A wasn't supposed to but she could just this one time. She gave him the medication.
Review of Resident #1's [redacted] electronic medication administration record (eMAR) revealed that he was scheduled to take [redacted] 650mg which is generic for the brand name [redacted] (pain relief for [redacted] take 1 tablet by mouth twice a day (every 12 hours). The medication was scheduled for 6:00am and 6:00pm. The eMAR indicated that the resident received his 6:00am dose of [redacted] 650mg on [redacted] even though he was transported to the hospital that morning around 3:30am.
Interview with the executive director on [redacted] at approximately 2:10pm revealed that the facility staff does not provide assistance with self-administration of "as needed" medication at this facility.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Grace Manor at Lake Morton, LLC
610 East Lime Street
Lakeland, FL 33801

Dear Administrator:

Re: **CCR# 2013008974**

This letter reports the findings of a complaint survey that was conducted on , 2013, by representative(s) 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 surveyor(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

FOR Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1161

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Grace Manor at Lake Morton, LLC.
610 East Lime Street
Lakeland, FL 33801

Dear Administrator:

This letter reports the findings of a complaint survey, CCR# 2013008974, conducted on , 2003, by a representative of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this mailed report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D

Directed Corrective Actions:

1. The Assisted Living Facilty is required to provide training with all staff on the facility Medical Emergency Policy. Special attention will be emphasized on what steps will be taken when a resident presents signs of being in immediate distress.
2. The Assisted Living Facilty is required to make sure all residents who are at risk for elopement will have on their person identification that includes their name, the faciltiy name, address, and phone number.
3. The Assisted Living Facilty is required to ensure that unlicensed staff do not adminster "PRN or As Needed" unless the order is written with specific parameters that preclude independent judgement on the part of the unlicensed staff and at the request of a competent resident.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call **Paul Brown**, HFES, at (727) 552-2000.

Headquarters
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Should you have any questions, please call **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,

Paul A Brown

Patricia Reid Caufman
FOR Field Office Manager

PRC/kpr