AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Emeritus At Ocala East
1601 S.E. 24th Road
Ocala, FL 32671

Dear Administrator:

Re: CCR #2013010718 & Biennial

This letter reports the findings of a state licensure survey that was conducted on , 2013 by representative(s) of this office.

Enclosed 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 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 this office at (386) 462-6201.

Sincerely,

Stephen Bergin for,

Kriste J. Mennella
Field Office Manager

KJM/amw

Enclosure

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

Alachua Field Office
14101 N W Hwy 441, Suite 800
Alachua, FL 32615-5669
Phone (386) 462-6201; Fax (386) 418-5300

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911441	10/17/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Ocala East	1601 S.E. 24th Road Ocala, FL 32671	
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= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
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

An unannounced visit to conduct a Biennial Relicensure survey was conducted on . . Complaint# 2013010718 was investigated at the same time. Deficiencies were identified at this time.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, record review and interview the facility failed through the prevention of ..... program implementation to ensure the safety of 3 of 3 residents (#1, 2, 3).

Findings:

Observation of Resident #1 on beginning at 9:50 AM during Initial Tour, revealed his door was open and he was in bed. He had only an ..... brief on, no sheet was covering him at that time. He stated he could not get out of the bed and he wanted to get up. His call bell was not visible. He stated he did not know where the call bell was located. This surveyor asked the Housekeeper where the Aide for this resident was located. This surveyor went to find her.

Further observation/interview on at 9:55 AM with the Aide assigned to Resident #1 revealed the Resident had a cover over him but no clothes on. The Aide was able to find his call bell stuck in between the wall and his mattress. She stated " he could get this out by himself ". She stated " we keep him in bed ". She stated he " could not sit in his wheelchair because he leans forward and ..... out. So we keep in the bed ", " unless we get him up for meals but he doesn ' t like to go to the dining , so we keep him in the bed ". She had no information regarding ..... prevention techniques, mats, sensors, or frequent checks. She had no information regarding any service plan directives. She had no response for any documentation of ..... prevention care she may be providing.

Review of the ..... /Event Trend Report for revealed Resident #1 had on at 7:45 PM, at 3:30 AM, at 10:00 PM, at 5:00 PM. The Nursing Notes for revealed a Late Entry for when the resident was observed to be on the floor in the hallway with his electric scooter on top of him. The Nursing Notes for stated he was " found on , there was no documentation for his ' 13 at 10:00 PM .. and the states he was found on the floor in his ....". There were no injuries noted. The resident ' s Assessment and Service Plan dated states " ..... Precautions " and Memory as " Forgetful ". His Health Assessment dated notes ..... under special precautions but there was nothing noted on his updated assessment dated . . . There was no explanation of this inconsistency in

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light of the recent ...l on , and no response for ... precautions at all. There were no directives for implementing any program. Review of Hospice Nursing Focused Note dated : states " resident ..l " with intervention to be " . reinstructon safety ...l precautions " . There was no information provided, noting how the facility responded to the recommendation .

During an interview with the Resident Care Director on at approximately 10:15 AM, she stated Resident #1 was on Hospice and that is why he stays in the bed all the time. She confirmed he had several .. recently. She could not provide any information regarding the facility ' s response to the ... except they informed the Hospice staff. She stated the resident had no ..... service plan and nor any response for whatever interventions they were providing were not documented. No further information was provided.

Review of Resident #2 ' s record revealed a Health Assessment dated : which notes " . ... Precautions " . The Hospice Collaboration /Review Agreement dated , notes ...l Mats under needed equipment. The Nursing Notes dated . stated " noted laying on floor, ...l on wash cloth with from forehead laceration " , on : the notes state the resident ... and hit her head, causing a laceration, on : it states " resident ..l in ...l her to hit her head " . There were no ...l precaution techniques or interventions noted. There was no .... interventions on any Service Plan provided. There was no mention of the Hospice recommendations of mats in any of the documentation. Further, after the resident ' s .... on she was transported to the emergency ..... admission. She was returned to the facility on . at 4:00 PM. She was under Crisis Care of Marion County in her ..... The resident rallied and Hospice discharged her from Crisis Care on On . she was transported to the Hospice House where the resident subsequently ...l on . There was no documentation of any additional . during that time period nor of requested 24 hour care.

Interview/Observation of Resident #3 on approximately 1:00 PM revealed she was had no information regarding any interventions the staff use for ...

Review of Resident #3 ' s record revealed a Health Assessment dated : states " ... " as a special precaution and in the diagnosis. She is also diagnosed with , and gait ataxia. Her records include Nursing notes dated and : l which she suffered ... where staff found her lying on the floor. Her Assessment /Service Plan dated , there was no revised Assessment/Service Plan, states the resident has a right hip ..... It states she requires assistance for mobility, check for appropriate footwear, evaluate ..... and hip savers offered. There is no further information provided regarding any interventions or directives for this resident.

Review of the facility's ...l policy dated , it states " complete Ambulation and Mobility Evaluation and implement initial interventions, additional interventions shall be addressed in the Service Plan". Further , it states the Resident Care Director will use the Post ...l Tracking Form to analyze each . l and implement new interventions.

During an interview with the Resident Care Director and the Administrator on : at 4;30 PM, they stated they were both newly hired employees. They stated they were not present during Resident #2 ' s stay in the

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facility. They had no information regarding the lack of precautions or Service Plan objectives regarding for Residents #1, 2, 3.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, record review and interview the facility failed to ensure a dignified environment for 1 of 3 residents (#1).

Findings:

Observation of Resident #1 on beginning at 9:50 AM during Initial Tour, revealed his door was open and he was in bed. He had only an brief on, no sheet was covering him at that time. He stated he could not get out of the bed and he wanted to get up. His call bell was not visible. He stated he did not know where the call bell was located. He was on This surveyor asked the Housekeeper where the Aide for this resident was located.

Further observation/interview on at 9:55 AM with the Aide assigned to Resident #1 revealed the Resident had a cover over him but no clothes on. The Aide was able to find his call bell stuck in between the wall and his mattress. She stated " he could get this out by himself ". She stated he just "yells" when he needs help. She stated " we keep him in bed ". She stated he " could not sit in his wheelchair because he leans forward and out. So we keep in the bed ", " unless we get him up for meals but he doesn ' t like to go to the dining so we keep him in the bed ". She pointed to the styrofoam bowl with dry corn flakes, covered in plastic wrap sitting on the bedside table. She had no information regarding any techniques they use to encourage him to eat. She stated she did not know why his clothing was missing. She had no information regarding any interventions for him regarding his privacy or dignity.

Review of Resident #1's record revealed no Assessment/Service Plans interventions regarding his meals, dressing, and access to call bells. He has a Hospice contract for issues. He suffers from all of the time, so calling for help is difficult.

During an interview with the Resident Care Director on at approximately 10:15 AM, she stated Resident #1 was on Hospice and that is why he stays in the bed all the time. She confirmed he had several recently. No further information was provided.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation record review and interview the facility failed to assist with Medication provision for 1 of 6 residents (#3)

Findings:

During Medication Provision on beginning at 12:00 PM, the Medication Technician for the 100 and 300

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hall provided pa-Levo 25-100 at 1:32 PM. Resident #3 took the pill cup and swallowed it with water. The resident was noted to be shaking.

Review of Resident #3's record revealed a Physician's Order Sheet dated It orders the 4 times daily at 8 AM, 11 AM, 4 PM, 8 PM. Her diagnosis is Parkinson's

An interview with the Medication Technician on at 2:30 PM revealed she was attempting to administrate the 11:00 AM medication to Resident #3. She stated she didn't realize she had a specific of time to provide the medications.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on record review and interview the facility failed to report an adverse incident in a timely manner for 1 of 10 residents reviewed for adverse incidents (#2).

Findings:

Review of the adverse incident reports provided by the facility for an incident for Resident #2 revealed they sent the first report on The second report was received by the state agency on Both reports were in regards to an incident on in which Resident #2 with serious head injuries.

An interview with the Resident Care Director on at approximately 10:45 AM revealed she thought the reports were submitted timely.

Class III