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	AL11911017	08/08/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Regency Residence	**5600 Lakeside Drive North Margate, FL 33063**	
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List of Tags Cited:

St - A - 0000 - - Initial Comments
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0092 - 58a-5.020(1) Fac - Food Service - General Responsibilities S-S= G
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= G
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced biennial standard Assisted Living Facility relicensure survey was conducted on . . . through . . . . . Emeritus at Regency Residence, had deficiencies found at the time of the visit.

This survey was conducted in conjunction with complaint inspections CCR#'s 2013001900, 2013002784 and 2013007209. The following citations were issued:
2013001900: A025, A032, A160
2013002784: A092 (Class II), A093, A152 (Class II)

This survey was also conducted in conjunction with an initial Limited Nursing Services (LNS) survey. There were no identified deficiencies for the LNS survey.

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0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on record review and interview, the facility failed to ensure a Health Assessment form was completed upon significant change and reflective of the resident's current health status and care needs, for 1 out of 3 sampled records reviewed (Resident # 60).

The findings include:

Review of Resident #60's current health assessment (AHCA form 1823) dated , noted a medical diagnosis of Parkinson's, , and . The health assessment noted the resident requires assistance with all ADL's (activities of daily living). The form did not reflect that care was being provided for .

During an interview with the Resident Care Director at approximately 11:00 AM on , it was reported that Resident # 60 had a decline in health after her admission and developed to her . The wounds were assessed by the physician and orders written for Home Health care. Review of the Nursing Service notes dated revealed the resident was placed on Home Health (HH) Services for care on . Further review of the Care Plan dated revealed the resident does not have or use outside agencies.

During an interview with the LPN unit manager on at approximately 1:30 PM, she stated that the resident's wounds continue to be treated by the Home Health Nurse. On at 3:00 PM during an interview with the Resident Care Director, she reviewed the current 1823 Health Assessment form and agreed that it did not reflect the resident's current level of care needs and daily care services that are being provided.

Class III

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

Based on observation and interview, it was determined the facility failed to provide appropriate supervision to a resident that had been identified as an elopement risk and requiring supervision, for, 1 out of 2 sampled resident records reviewed (Resident #43).

The findings include:

Review of Resident #43's record conducted on . . . . revealed she was admitted to the facility on . . . . Her medical examination dated . . . documented pertinent diagnoses of Advanced . . . . and High . . . . with . . . behavioral status noted as . . . . . Further review of the health assessment notes the resident is independent with all Activities of Daily Living (ADLs) except bathing which the resident needs supervision. Nurses notes documented she eloped from the facility on . . . . at 2:00 PM and was found wandering near (...). Her Individualized Service Plan dated . . . documented she was alert and oriented to person only, had periods of . . . and forgetfulness and sometimes understands others. She required occasional reminders to find areas within the community (e.g., apartment, . common areas) and required direction to go to meals.

Resident #43 was observed several times during the survey wandering in the facility very . and not orientated to place or time.

1. On . . . . at approximately 2:00 PM, Resident #43 approached this Surveyor in the dining . . . . said she was looking for her boyfriend. When asked what . . . lived in, she said, "I do not remember." The Assistant Dining . approached and redirected the resident to the television . . . In an interview conducted . . at approximately 2:10 PM, the Assistant Dining . stated, that she has never seen Resident #43 leave the building. It was also revealed, "She often comes in the dining . . . . . for her boyfriend or asks me where she should be."

2. On . at 2:31 PM, Resident #43 approached this Surveyor and asked where her . . . . She stated she asked her son to find her. "I haven't seen him and I'm looking for him. I saw him earlier." She further stated, "I've been told it's dangerous to go outside. To some places, I wouldn't go outside. There's a pond outside I would go there but I can't unless it's something I need a man or woman to do something with." The resident then continued to walk down the hall; no facility staff was present in the area. In an interview conducted . . . . at 1:56 PM, Staff #4 stated the resident does not have any children.

3. On . . . . at 2:39 PM, Resident #43 was observed looking for a seat outside near the facility's swimming pool used by assisted living residents. The pool was surrounded by a fence and had one gate that exited to the parking lot, and a partially-fenced pond across the street. No facility staff was observed monitoring the residents in the pool or in the pool area. The gate was tested and did not latch securely. On . at 12:00 PM, the Director of Maintenance observed the gate and stated, "The gate would close 90% of the time, but I could see that 10% of the time, it would not."

4. On . . . . at 10:30 AM, Resident #43 said she lived here and was not sure what apartment she

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lived in and didn't know how to get there. She stated, "This is a big place." She said that she was looking for her friend and that they have pleasure together which she explained as, "We both work hard and when you work and enjoy things, you have pleasure."

During an interview with the Resident Care Director (RCD) on at 11 AM, she confirmed aforementioned events. She also confirmed the last Unsupervised Absence Evaluation was conducted on and an updated evaluation had not been conducted after her elopement as per the facility's Unsupervised Absence Management procedures. She stated, "I don't feel she's at risk because she's usually in the dining her boyfriend and not exit-seeking." The RCD acknowledged any resident with a history of elopement or assessed as at risk for elopement must be cared for according to pertinent assisted living facility regulations.

Class III

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC

Based on observations, interviews and record review, the facility failed to ensure a resident at risk for elopement had required identification on them at all times and was included in the facility's elopement binders, for 1 out of 5 sampled residents (Resident #43); and failed to include a required provision in the facility's written resident elopement response protocol.

The findings include:

1. Review of Resident #43's record conducted on revealed she was admitted to the facility on Her medical examination dated documented pertinent diagnoses of Advanced and High with behavioral status noted as Further review of the health assessment notes the resident is independent with all Activities of Daily Living (ADLs) except bathing which the resident needs supervision. Nurses notes documented she eloped from the facility on at 2:00 PM and was found wandering near (...). Her Individualized Service Plan dated documented she was alert and oriented to person only, had periods of and forgetfulness and sometimes understands others. She required occasional reminders to find areas within the community (e.g., apartment, common areas) and required direction to go to meals.

Resident #43 was observed several times during the survey wandering in the facility very and not orientated to place or time:

2. On at approximately 2:00 PM, Resident #43 approached this Surveyor in the dining said she was looking for her boyfriend. When asked what lived in, she said, "I do not remember." The Assistant Dining approached and redirected the resident to the television In an interview conducted at approximately 2:10 PM, the Assistant Dining stated, that she has never seen Resident #43 leave the building. It was also revealed, "She often comes in the dining for her boyfriend or asks me where she should be."

3. On at 2:31 PM, Resident #43 approached this Surveyor and asked where her She stated she asked her son to find her. "I haven't seen him and I'm looking for him. I saw him

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earlier." She further stated, "I've been told it's dangerous to go outside. To some places, I wouldn't go outside. There's a pond outside I would go there but I can't unless it's something I need a man or woman to do something with." The resident then continued to walk down the hall; no facility staff was present in the area. In an interview conducted at 1:56 PM, Staff #4 stated the resident does not have any children.

4. On at 2:39 PM, Resident #43 was observed looking for a seat outside near the facility's swimming pool used by assisted living residents. The pool was surrounded by a fence and had one gate that exited to the parking lot, and a partially-fenced pond across the street. No facility staff was observed monitoring the residents in the pool or in the pool area. The gate was tested and did not latch securely. On at 12:00 PM, the Director of Maintenance observed the gate and stated, "The gate would close 90% of the time, but I could see that 10% of the time, it would not."

5. On at 10:30 AM, Resident #43 said she lived here and was not sure what apartment she lived in and didn't know how to get there. She stated, "This is a big place." She said that she was looking for her friend and that they have pleasure together which she explained as, "We both work hard and when you work and enjoy things, you have pleasure."

6. Review of three facility binders kept at the front desk and north and south wings conducted revealed names and photos of residents at risk for elopement. Further review revealed Resident #43's name and photo was not in any of the three binders. In an interview conducted around 11:00 a.m., the Resident Care Director (RCD) stated if a resident on the elopement risk list is considered no longer at risk, they are taken off the list. She first stated she did not know why Resident #43 was taken off the list. She also confirmed the last Unsupervised Absence Evaluation was conducted on and an updated evaluation had not been conducted after her elopement as per the facility's Unsupervised Absence Management procedures. She stated, "I don't feel she's at risk because she's usually in the dining her boyfriend and not exit-seeking." The RCD acknowledged any resident with a history of elopement or assessed as at risk for elopement must be cared for according to pertinent assisted living facility regulations.

A subsequent review of the three elopement binders conducted at 10:20 AM with the RCD present revealed Resident #43 was included in the binders for the front desk, and the north wing (where her apartment is located), but was still not included in the south wing binder.

7. Resident #43 was observed on around 2:00 PM with no visible form of identification showing her name and the facility's name, address and telephone number.

A subsequent review of the three binders conducted at 10:20 AM with the RCD present revealed Resident #43 was included in the binders for the front desk and the north wing (where her apartment is located), but was still not included in the south wing binder. However, this was two days after it was discovered Resident #43 was not listed as an elopement risk as identified by the facility on

8. Review of the facility's written elopement protocol titled Unsupervised Absence Management Policy and Procedures revealed no reference to provision of continued care to all other resident during facility

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response to a eloped resident. This was discussed with and acknowledged by the Regional Director on around 10:00 AM.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation, interview and record review, the facility failed to ensure the proper administration of inhalation treatment for, 1 out of 1 sampled medication pass observed (Resident #62).

The findings include:

On at 11:45 AM observation was made of Aide #1 administering ProAir HFA 90 mcg to Resident # 62. Resident #62 was prescribed ProAirHFA 2 puffs every 6 hours. Aide #1 was observed to hand the resident the inhalator; the resident took 2 quick puffs from the inhalator. The Aide handed the inhalator to the resident but failed to shake the medication prior to giving it to the resident. Further observations revealed the resident was not instructed to wait between the puffs. The resident administered her medication without waiting one minute between doses.

Observation of the pharmacy labeled pouch containing the inhalator, revealed the following instructions: Shake well before using. Wait 1 minute between puffs.

On at 12:05 PM during an interview with Aide #1, she reviewed the pharmacy label for the inhalator. She agreed that she did not shake the medication or have the resident wait 1 minute between puffs. She agreed that medications are to be administered as ordered.

On at approximately 4:45 PM during an interview with the Resident Care Manager (LPN), she stated that all nursing and unlicensed staff that assist with medications had attended a training seminar presented by the contracted pharmacy. She provided the training materials confirming this staff member had attended training in 2012. The Care Manager reviewed the manual and confirmed that inhalators are to be shaken prior to use and wait 1 minute between doses.

The Care Manager provided evidence that Aide #1 had attended continuing education training for Assistance with Medication Pass Technique on . The Care Manager stated that the aforementioned medication should have been administered as ordered.

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0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on record review and interview, the facility failed to ensure staff provided the required statements showing they do not have any signs or symptoms of a communicable and/or for 4 out of 5 sampled staff member files (Staff #'s 7, 8, 9 and 10).

The findings include:

1. A record review of staff members # 7, 8, and 10's personnel files conducted revealed no statements from a health care provider that the staff member was free from signs and symptoms of a communicable and/or

2. A record review of staff member # 9's personnel file revealed that there was no statement from a health care provider that he was free from signs and symptoms of a communicable

In an interview conducted on at 1:30 PM with the Business Office Director confirmed the findings.

Class III

0092-Food Service - General Responsibilities 58A-5.020(1) FAC
Based on observation, record review and interviews, it was determined the facility failed to ensure safe and sanitary food service operations for all 170 residents currently living at the assisted living facility; and failed to ensure the Food Service Designee (Staff #9) received the required training related to nutrition and food service in an assisted living facility.

The findings include:

I. A brief tour of the kitchen conducted on at 10:41 AM revealed numerous rodent feces in three pantries observed. The food supply pantry was noted to have an overwhelming foul odor of decomposition later identified by the Food Service Manager as rodents that were retrieved from the inside of the pantry wall. The local Health Department was promptly notified and arrived at 1:30 PM; the following violations were issued by the local Health Department:
1. Interior of ice machine soiled
2. improper hold temperature for tuna salad observed at 50.1 degrees Fahrenheit
3. improper hold temperature for chicken salad observed at 46.78 degrees
4. improper hold temperature for salami observed at 44/1 degrees Fahrenheit

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5. improper hold temperature for bologna observed at 45.7 degrees Fahrenheit
6. improper hold temperature for egg liquid observed at 55.3 degrees Fahrenheit
7. improper hold temperature for shred tomatoes observed at 55.3 degrees F
8. improper hold temperature for ham observed at 53.2 degrees F
9. unlabeled undated food containers observed:
   (i) in storage areas
   (ii) in the freezer
   (iii) in the walk-in cooler
10. Food containers were observed stored on floor in multiple areas of kitchen
11. Dirty equipment in:
   (i) kitchen
   (ii) storage
   (iii) salad bar
   handwash sink
   (v) hosery for drinks
   (vi) cabinets in kitchen
12. Rodent feces on top of containers

A determination to close the facility's kitchen was made by the local Health Department on at 1:42 PM. The facility was informed by the County inspector that no further food service could be conducted at the facility until the above violations were corrected and the kitchen was emptied of all foods, thoroughly cleaned and sanitized, and free of rodents. This was discussed and acknowledged with the Administrator at time of closure. The facility's kitchen was granted permission to reopen on (during a revisit by the health department) and allowed to continue food preparation and service by the local Health Department.

II. Record review of the facility's food service designee (Staff # 9) personnel file conducted revealed he did not have the required annual minimum two hours of training in nutrition and food service in an assisted living facility, provided by a certified food manager, licensed dietician, registered dietary technician or health department sanitarian.

In an interview conducted at 1:30 PM, the Business Office Director concurred that employee #9 did not have the required 2 hours of nutrition and food service training by a qualified trainer.

Class II

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0093-Food Service - Dietary Standards 58A-5.020(2) FAC

Based on observations, interviews and record review, the facility failed to ensure therapeutic diets were provided, for 5 of 8 sampled residents requiring a therapeutic diet (Resident #23, #24, #46, #47 and #1). It was also determined the facility failed to post the current menu and failed to maintain required records relating to therapeutic diets and menu substitutions.

The findings include:

1. Observation of the lunch food service conducted on at 12:05 PM was conducted and resident #23 was observed being assisted with her lunch meal by her private duty aide (PDA). The PDA was observed to have a plastic cup from which she was adding powdered thickener to the resident's juice. An interview was conducted with the PDA on at approximately 12:10 PM, she stated the glass is supposed to be about 8 ounces and she adds the thickener, but she does not think the resident needs it. She states there is no set amount of thickener that she adds to the liquids. The resident was later observed served coffee to which the PDA was observed to not add the thickener. Further observation of the lunch meal revealed the resident was served a regular hamburger with sliced tomatoes and lettuce, french fries, lentil soup and banana cream pie.

Review of Resident #23's record revealed a health care provider's written therapeutic diet order dated for a pureed diet and nectar-thick liquids due to a diagnosis of Observation of the posted special diet list located in the facility's satellite kitchen where the resident takes her meals revealed Resident #23's name was not listed. A special diets list obtained from the Nursing Department on at 10:35 AM, documented the resident to require only nectar-thick liquids.

In an interview conducted at 10:46 AM, a licensed practical nurse (LPN #1) assigned to Resident #23 stated she was just made aware Resident #23 was on a pureed diet and did not know when it was ordered. In an interview conducted at 10:54 AM, the Resident Care Director (RCD) stated, she updates the diet list quarterly and/or every 6 months unless there is a change. She stated she gave an update to the kitchen Manager upon receipt of the change in the resident's diet order. She reviewed the kitchen's posted special diet list and confirmed Resident #23 was not listed.

During an interview conducted on at 8:10 AM, the Food Service Manager (FSM) stated he is aware the resident is on a pureed diet but was not sure why she was not served a pureed meal for lunch and that staff should have known. When asked about his puree preparation techniques, he stated he had not been trained in how to properly puree foods for the assisted living residents.

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2. Resident #24 was observed during the lunch meal on at 12:15 PM in the satellite dining her PDA and was observed to be eating a hamburger on a and french fries with lettuce and tomatoes and beans. The PDA attempted to mash the beans, pie, and other items so the resident could eat. In an interview conducted at 12:17 PM, the PDA stated the resident has difficulty eating the food as served.

Record review conducted of Resident #24's health assessment dated documented pertinent diagnosis of High and and required a mechanical soft diet.

In an interview conducted at 2:20 PM, the RCD confirmed the special diets lists were current and did not include Resident #24's mechanical soft diet. She stated she was unaware that the resident had a special diet requirement.

3. Resident #46 was observed on at 12:15 PM, eating a cheeseburger cut in half. She stated at that time, "I have and have a hard time swallowing." On at 10:41 AM, the Food Service Manager (FSM) pointed to a bulletin board with a picture of Resident #46 and "mechanical soft diet" listed beneath it.

Record review conducted on of a medical examination dated revealed Resident #46 has and required assistance to cut her food. A physician's order dated documented, "Please cut food into small pieces at all meals." A copy of an identical order with additional verbiage stated, Give to Kitchen." A review of the Nursing Staff's Special Diet list includes Resident #46 and states to "cut up in small pieces."

Resident #46 was observed on at 12:15 PM in her wheelchair, her upper torso curved sharply to one side and a speech impediment made it difficult for her to communicate verbally. In an interview conducted on at 8:10 AM, the FSM acknowledged Resident #46 received a cheeseburger that was not cut in to small pieces and stated he was told when he started that if it was a resident's preference to have something not on their diet, to not question it. He stated he did not know a resident had to sign off if they did not want to comply with a health care provider ordered therapeutic diet. There was no documentation in the resident's record showing non-compliance with her therapeutic diet.

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4. Review conducted on of Resident #47's record revealed a medical examination (AHCA Form 1823) dated that documented she needs supervision for meals. The health assessment documented a diet order of "No Added Salt, Mechanical Soft diet".

During lunch observation on from 12:00 and 1:00 PM (South Wing dining one staff member was present serving meals. No staff member was observed supervising Resident #47. Her lunch consisted of a hamburger with lettuce and tomatoes, baked beans, and french fries.

The FSM on at 10:41 AM pointed to a bulletin board that had a picture of Resident #47 and "mechanical soft diet" listed beneath it. Further interview at 10:54 AM, the FSM stated Resident #47 is no longer on a mechanical soft diet and "We must have forgotten to take it down." referring the Resident #47's photo and therapeutic diet. In an interview on at 8:10 AM, the Food Service Manager stated Resident #47, ..."is off mechanical diet, I believe". He stated he did not know as she usually has soup and a couple slices of fruit for lunch." He stated he did not know a resident had to sign off if they did not want to comply with a health care provider ordered therapeutic diet. There was no documentation in the resident's record showing non-compliance with her therapeutic diet.

5. Review of Resident #1's record revealed she was admitted to the facility on Review of Resident #1's health assessment form (AHCA Form 1823) dated documented a pertinent diagnosis of The assessment form also documented the resident requires services three times weekly. Special precautions documented as fluid overload, diet noted as regular consistency with no added salt and low fat/cho with fluid restrictions. Further record review revealed Hospital discharge instructions dated documenting the resident's diet as diet.

Review of both the kitchen and nursing special diets lists conducted reflected no diets were being provided at this time. This was discussed with and acknowledged by the RCD on around 9:10 AM. The RCD further stated that no residents (including Resident #1) are currently being served a diet. Therefore, the facility failed to ensure Resident #1's therapeutic diet was prepared and served as physician ordered.

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6. Observation of the posted menu conducted at approximately 10:00 AM, revealed the menu was dated 2013, there was no current menu posted. On at 5:01 PM, the prior 6 months of therapeutic diet menus and menu substitutions was requested; the FSM stated that these records were not available for review.

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC

Based on observations, interviews and record review, the facility failed to provide a safe living environment for residents by not eliminating an on-going problem with vermin, and not maintaining plumbing and mechanical systems and appurtenances in good working order. This had the potential to affect all of the 170 residents currently living at the assisted living facility.

The findings include:

As referenced in Citation A092 herein, the facility's kitchen was placed out of service as mandated by the local health department on related to the presence of rodents. The facility's kitchen was granted permission to reopen on (during a revisit by the health department) and allowed to continue food preparation and service by the local Health Department.

The findings below are pertinent to the concerns identified in Citation A092.

1. Review of the facility records revealed the following documentation:

A. Pest control vendors' service reports conducted revealed the following pertinent recommendations:

a) A report dated documented:
Findings/Conditions: Attic, soffit, gable or turbine vents need tight-fitting screens and/or hardware cloth to exclude pests and rodents. Weather stripping on door/window needs replacing/repair.
Recommendations: Seal/screen attic and roof vents. Repair/replace weather stripping.

b) A report dated documented:
Findings/Conditions: Accumulated debris in dock pits needs cleaning to prevent rodent and insect pests. Keep dumpster lid closed to attract fewer flies and other pests.
Recommendations: Remove debris in dock pits. Secure dumpster lid.

c) A report dated documented service to resident 282, 340 and 360:
Structural concerns that could cause pest problems: Hole/gap noted, there are multiple holes in and around building and other areas that was showed to [Maintenance Assistant]. Seal to prevent pest entry or harborage.

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Sanitation issues that could cause pest problems: Exterior Area - Trees/shrubs are contacting the facility creating a path for pests to enter. Trim back this vegetation to eliminate contact.

d) A report dated documented: Structural concerns that could cause pest problems: Laundry Area/Housekeeping Exit door found open. Remind employees to keep door closed. Install screen door, auto-door closer.

e) A report dated documented:
Comments: Food prep area: Need to fix all the holes around the kitchen.

f) A report dated documented service to resident 282, 340 and 360:
Structural concerns that could cause pest problems: Kitchen - Exit door found open, remind employees to keep door closed. Laundry Area/Housekeeping - Exit door found open. Remind employees to keep door closed. Install screen door, auto-door closer. Exterior Area - Trees/shrubs are contacting the facility creating a path for pests to enter. Trim back this vegetation to eliminate contact.

g) A report dated documented service to resident 156, 210, 382 and 389; rodent elimination treatment was provided during this visit.

h) A report dated documented service to "apartments" but did not identify resident

Structural concerns that could cause pest problems: Hole/gap noted multiple openings around perimeter on north side of property. Seal to prevent pest entry or harborage.
Sanitation issues that could cause pest problems: Exterior Area - Trees/shrubs are contacting the facility creating a path for pests to enter. Trim back this vegetation to eliminate contact.

i) A report dated documented service to resident
Sanitation issues that could cause pest problems: Exterior Area - Trees/shrubs are contacting the facility creating a path for pests to enter. Trim back this vegetation to eliminate contact.

j) A report dated documented:
Sanitation issues that could cause pest problems: Exterior Area - Trees/shrubs are contacting the facility creating a path for pests to enter. Trim back this vegetation to eliminate contact.

k) A report dated documented:
Sanitation issues that could cause pest problems: Exterior Area - Trees/shrubs are contacting the facility creating a path for pests to enter. Trim back this vegetation to eliminate contact.

B. A letter dated from the facility's new (as of pest control vendor disclosed visits conducted and Service reports for and as well as a report for were reviewed and none of the reports documented rodent elimination treatments to any specific resident Service reports for visits conducted and were requested from the facility's Maintenance Director on at 1:45 PM but were not received for review prior to the conclusion fo the survey. The letter included the following references: The facility faxed over the requested reports on to the Agency for review.

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	AL11911017	08/08/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
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Review of the requested reports revealed:
On , "The service pro checked traps removed one from kitchen attic."; and on , the only potential reference by the new pest control vendor to treatment of resident disclosed, "I was on property and inspected three units for rodents. There was on with some evidence I placed out traps in the water cooler area and inspected for holes."

C. An entry in a pest control Service Request Log dated documented mice in resident 190 and 389. Review of the corresponding pest control vendor service report dated documented services for insects only, there was no reference to rodent elimination treatment provided during this visit.

D. Entries in the facility's Work Order Book, all dated (the day following rodent elimination treatment in the facility's kitchen) documented resident sightings and/or requests for rodent elimination services as follows: for "mice/rat needs trap", "wants more traps", and "saw mouse".

In an interview conducted at 3:45 PM, the resident living in confirmed she reported seeing a mouse and stated she saw it on the floor in the nook where the air conditioning vent is located; it ran into the vent. She made reference to tapping noises coming from her ceiling, she thought it was from people living above her. When reminded she lived on the top floor, a surprised and concerned look came over her face and she said, "Then what it it? I hope there's not something running around over my head up there!"

E. A hand-written list titled Pest Control related to resident 190, 370 and 389 disclosed:
1) Put door sweep on water heater door
2) Check traps
3) Check traps; put moth balls in and around north side building
4) 7/2 Check traps; found one mouse in trap, toss out and replaced trap
5) 7/5 Load out traps in 189, 289, 389A
6) Found two mice in traps, toss and replaced
7) 8/1 Found one mouse in trap, toss and replaced

During an interview conducted at 11:04 AM, the Maintenance Director stated he started his own treatment program because he felt the prior pest control vendor's services were inadequate. Further interview at 11:38 AM on , while accompanied by the Maintenance Director, resident was observed. The vacant and revealed about six rodent glue traps within the unit; the air conditioning vent had been sealed around the edges. The two resident closest to 389 were observed and revealed they were vacant and each had about four rodent glue traps within the units.

The facility was aware of an ongoing rodent control problem evidenced by pest control vendor recommendations back through 2013. Trees and bushes making contact with the building; holes in exterior and interior walls; inadequate doors and seals; staff practices related to food handling, trash handling, and leaving exit doors open were allowed to continue and not permanently corrected or maintained. Based on the aforementioned, it was determined the facility did not take adequate steps to control and eliminate an on-going rodent problem. These concerns were discussed with the Administrator on at 8:24 AM.

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2. A walk around the outside of the building conducted at 3:25 PM while accompanied by the Maintenance Director revealed most of the trees and shrubs located adjacent to the building were in contact with the building. The Maintenance Director stated the trees and shrubs had been cut back previously but acknowledged most of them were in contact with the building. He stated facility staff are limited as to the height they are allowed to trim the trees and bushes.

3. On beginning at 2:45 PM, the following observations were made during a tour of the facility and grounds while accompanied by the facility's Maintenance Director:

a. The building holds two trash chutes that begin on the third floor and empty on the first floor in to a trash dumpster. Each floor has a front-opening trash chute door in a small trash a door. Inspection of the trash revealed the following:

i. The trash chute door located on the first floor north wing would not close. The dumpster was in view and was full. A 30-gallon trash can used for extra trash was overflowing. A cardboard box and five plastic bags containing trash and garbage were on the floor. Loose trash and debris littered the trash chute

ii. The trash chute door located on the first floor south wing was missing. The dumpster was in view and was full. A 30-gallon trash can used for extra trash was overflowing. Four plastic bags containing trash and garbage were on the floor. Loose trash and debris littered the trash chute

iii. The trash chute door in the trash chute on the second floor north was left open. Three cardboard boxes and a soiled latex glove and dark residue was observed on the trash chute

b. The area around the north outdoor dumpster was observed with a bag of trash and loose debris on the concrete floor. The double-doors to the dumpster area were left wide open. A 1 1/4" gap was observed at the bottom of the doors. The Maintenance Director was asked and stated staff members were supposed to keep these doors closed.

c. The metal trim at the bottom of the rear kitchen exit door was half broken off, leaving a gap between the bottom of the door and the threshold.

4. A sink valve in unoccupied resident was in disrepair and a significant water leak was seen. The carpeting outside the noticeably wet in an area about 5'x15'. The air conditioning vent located above this area had an excessive black dusty substance on the vent and a surrounding area of about 3'x5'.

5. An air conditioning unit located to the right of resident was leaking and water damage to the wall was observed where the ceiling meets the wall; at the bottom of this area the wall material was deteriorating and exposed rusted metal, the floorboard was deteriorating, an air conditioning vent in the same area was soiled with a gray fuzzy substance.

6. The exterior windows in the hallway near resident had a significant amount of green substance on the exterior of the windows and was very unsightly. About a third of the first-floor windows observed were soiled and unsightly. About half of the windows on the second and third floors had moderate to significant amounts of soil and/or green substance on the exteriors of the windows and were unsightly. The Maintenance Director was asked and stated the exterior windows had not been

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cleaned in about eight months, and the exterior windows on the second and third floors had never been cleaned in the two years he has been the Maintenance Director.

7. The following areas of carpeting were stained and unsightly:
a. At the left side of the entrance to the emporium, a white circular stain about 12" in diameter
b. Near resident , a dark stain about 18" in diameter
c. Near resident , the carpet is loosed and has "wrinkled"
d. Near resident , a dark stain about 2' in diameter

8. On at approximately 11:08 AM, the laundry the second floor of the North Wing was noted to have two washers and two dryers. The tops of the machines were dirty and enamel was peeling off on the machines. It was noted that two kitchen linens and a plastic bag of clothes on shelves above the machines and the ceiling vent were dust-laden.

9. In a brief tour on at 11:51 AM with a member of the maintenance staff, the trash the first floor had a lined garbage can with an open chute to the dumpster behind it. An empty pizza box and a rotted banana peel were among items on the floor next to the garbage can. The staff member stated that, "This garbage should not be here." He said that small items can be put in the garbage bin but most items should go through the chute into the dumpster. A sign posted in the trash "This is not a trash use dumpster inside." The staff member said there have been reports of mice in resident on the third floor of the north wing which is, "an issue we are working on."

10. An observation on at 3:17 PM, an unlocked electrical the South wing, first floor had baseboards that were peeling and deteriorating.

11. An observation conducted on at 3:24 PM, a vent on the South wing, 2nd floor, near an unlocked phone/electrical laden with dust.

12. An observation of the South Wing on the first floor conducted on at 9:15 AM, revealed a green substance on multiple windows in hallways and was unsightly. The wall in the television in disrepair with paint peeling and dents in it. A hardened substance appeared to have dripped down to the air conditioning vent next to the electrical

Class II

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0160-Records - Facility 58A-5.024(1) FAC

Based on record review and interviews, the facility failed to ensure that major incidents were thoroughly investigated and documented for 3 of 5 sampled sampled residents (Resident #43, #49 and #50); records did not properly reflect the underlying causes of the incidents or steps taken to prevent recurrence.

The findings include:

1) A record review conducted on [redacted] of nurses notes documented Resident #43 eloped from the facility on [redacted] and was found wandering near [road]. Further review of facility records and Resident #43's record revealed no investigation was conducted related to this incident. On [redacted] at 4:00 PM, a request was made to the Administrator for any investigation documentation regard aforementioned incident. He stated, "If it's not there, we don't have it."

2) A record review conducted on [redacted] of an adverse incident report for Resident #49 documented the resident eloped on [redacted] and was found near [road]. The cause was listed as, "family employed a Private Duty Aide (PDA) and no further issues". This was not an underlying cause. There was no documentation showing all steps on the facility's Missing Resident Response Worksheet were completed per the facility's written Unsupervised Absence Management Policy and Procedures.

3) A record review conducted on [redacted] of an adverse incident report for Resident #50 stated, the resident eloped on [redacted] and was found near [road]. The cause was listed as, "placed on one to one supervision and the family and transferred to a sister facility." This was not an underlying cause. Transferring the resident to another facility three days after the incident did not absolve the facility of their responsibility to implement interventions during those three days the resident remained at the facility. There was no documentation showing all steps on the facility's Missing Resident Response Worksheet were completed per the facility's written Unsupervised Absence Management Policy and Procedures.

These concerns were discussed with and acknowledged by the Resident Care Director on [redacted] around 1:00 PM. She confirmed that the facility had not completed an adverse incident report and submitted to the Agency for aforementioned incidents.

Class III

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AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Emeritus At Regency Residence
5600 Lakeside Drive North
Margate, FL 33063

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2013 by a representative from 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 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 representative. Should you have any questions please call this office at (561) 381 - 5840.

Sincerely,

Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure

XG90

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