STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967298	10/14/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Avalon's Assisted Living Ii	13230 Early Frost Circle Orlando, FL 32828	
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= D

Specific Tag Findings:

0000-Initial Comments
An unannounced complaint inspection complaint # 2013010676 was attempted on [redacted]. There was no one at the facility and the Administrator did not come to the facility when requested by the Survey Team. A second unannounced visit was made on [redacted].

The Avalon's Assisted Living Facility II had deficiencies at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review and interview the facility failed to contact the residents health care provider and other appropriate party's such as the resident's family, guardian or case manager when a resident exhibited a significant change for 1 of 4 residents reviewed (Resident #1).

Findings:

Telephone Interview conducted on [redacted] at 11:00 AM with a family member of resident #1 who stated that she has medical issues that prevent her from driving. She is unable to see resident #1 on a regular basis. She explained that resident #1 is non- verbal. Upon admission the resident was ambulatory and able to eat and swallow food and he had no [redacted]. The family member relies on the administrator to tell her what his status is. The family member further stated she called the administrator regularly for information on the resident's status. The resident was admitted on [redacted] weighing 205 pounds. On [redacted] the family member called the administrator to discuss bringing a birthday cake to the facility for the resident's birthday. At that time the administrator told the family member the resident "is doing fine". The family member arrived at the facility on [redacted] and found that the resident had lost a great amount of weight. He was wheel chair bound and was not able to swallow. She stated she "was shocked to see his decline". She asked the administrator to arrange for resident #1 to have a full medical examination. The family member stated that the administrator refused to take the resident to see a physician. The family member left the

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facility and made arrangements for the resident to be taken to the Winter Garden Veterans Hospital on . The physician who initially examined the resident directly admitted him to the hospital. The resident was admitted with and a on his tail bone. The family Member stated she was never informed of the change in the resident's change in condition.

Record Review conducted on at 11:00AM for resident #1 revealed a Facility Health Assessment Form (AHCA Form 1823) dated with diagnosis of Aggressive Behavior and Rule out Major and rule out behavioral disturbances. The physician indicated he required assistance with self- administration of medications, regular diet with no and requires assistance with activities of daily living. The 1823 indicated the residents mediations on admission were 0.5 mg 3 x daily by mouth, 100 mg every AM by mouth, 400 mg every PM by mouth, 1000 mg twice a day by mouth and XR 150 mg every AM by mouth. Review of the residents MOR dated revealed that his mediations were given as ordered.

Further review of the record for resident #1 revealed a weight record with one entry on it. The entry was dated and indicated a weight of 205 pounds. Also there was documentation in the resident's record in reference to the resident's weight loss. Further review of the record did not reflect that the resident had a Further record review revealed there was no documentation of when the was first observed, if the resident's family and physician was notified. There was no documentation that the resident received any treatment for the Several attempts were made to contact the resident's health care provider.

Observation of Nursing Notes for Resident #1 revealed:

Note dated resident #1 taken to the Veterans Clinic for evaluation and to assess for supplies such as diapers.
Note dated Resident #1 taken to VA walk in clinic. The note did not indicate why the resident was seen or what the outcome was.
Note dated that the Administrator purchased supplies for the resident.
Note dated reveals that the resident was seen by ARNP Laverne. The note did not indicate why the resident was seen or what the outcome was.

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Review of the Facility Contract dated and signed by the Administrator and the Residents Wife revealed a hand written addendum "family agrees to provide toiletries and supplies and understands facility does not pay co-pay of any kind". It is initialed by the administrator and the resident's wife.

Review of Records from Winter Park Veterans Hospital regarding resident #1. The records are dated

Current History and Physical:

Physical Examination: Elderly male lying on a stretcher in the ER, in no acute distress. He opens his eyes. Nods "yes" and "no" to simple questions. He is nonverbal. Per patient's wife, this is his baseline. Vital Signs: at present is Pulse 80, saturation on 3 liters 100%, rate 13 breaths per minute.

ASSESSMENT AND PLAN:

1.
2. **insufficiency.**
3. **Severe hypernatremia. fluids. Basic panel later today.**
4. **Monitor**
5. **care evaluation.**
6. **Positive troponin. He denies any chest pain or and troponin q8h. X 3. evaluation.**
7. **Mental status at baseline per patient's wife.**
8. **prophylaxis. Per patient's wife he is mostly lying in bed. Patient is not with keeping on SDs. Per patient's wife he has not had any recent surgeries. No history of problems.**

Care Report dated By Barton RN, CWOCN
Active Orders:
Left Medial Present on admit
Stage
Drainage Amount Scant
Drainage Character
Activity Assessed

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Length	**3 cm**
Width	**2 cm**
Surface % Red	**100 %**

Interview conducted on [redacted] at 2:50 PM with administrator who stated she had no knowledge of where resident #1 was at this time. He was taken to a physician appointment arranged by the family and did not return to the facility. During resident #1's stay at the facility she did suggest to the family member that he could benefit from an ensure type drying/shake. The family refused to pay and the Veterans hospital did not supply it. Administrator stated she purchased a month's supply of the shake on [redacted]. The administrator admitted that she was aware that the resident had weight loss due to his [redacted] process; however there was no documentation in the record of what [redacted] process the weight loss was related to. Also, there was no documentation resident's physician was notified of the weight loss. Therefore there was no physician ordered interventions or approaches. When asked about the resident having a [redacted] the administrator stated she had no idea.

Class II

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review and interview the facility failed to provide access to appropriate health care for 1 of 4 sampled residents (#1) when a family member expressed a significant change in status.

Findings:

Telephone Interview conducted on [redacted] at 11:00 AM with Wife/ Family Member of resident #1 who stated that she has medical issues that prevent her from driving. She is unable to see resident #1 on a regular basis. Resident #1 is non-verbal. Upon admission resident was ambulatory and able to eat and swallow food and he had no [redacted] Family member relies on the administrator to tell her what his status is. The family member stated she called the administrator regularly for information on the resident's status. The resident was admitted on [redacted] weighing 205 pounds. On [redacted] the family member called the administrator to discuss bringing a birthday cake to the facility for the resident's birthday. At that time the administrator told the family member resident "is doing fine". Family Member arrived at the facility on [redacted] and found that the resident had lost a great amount of weight. He was wheel chair bound and was not able to swallow. She stated she

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"was shocked to see his decline". She asked the Administrator to arrange for resident #1 to have a full medical examination. The Family Member stated that the administrator refused to take the resident to see a physician. The Family Member left the facility and made arrangements for the resident to be taken to the Winter Garden Veterans Hospital on . The physician who initially examined the resident directly admitted him to the hospital. The resident was admitted with and a on his tail bone. The family member stated she was never informed of the change in the resident's condition.

Resident Record Review conducted on at 11:00AM for Resident #1 revealed a Facility Health Assessment Form (AHCA Form 1823) dated with diagnosis of Aggressive Behavior, and rule out Major and rule out behavioral disturbances. The physician indicated he required assistance with self- administration of medications, regular diet with no and requires assistance with activities of daily living. The 1823 indicated the residents mediations on admission were 0.5 mg 3 x daily by mouth, 100 mg every AM by mouth, 400 mg every PM by mouth, 1000 mg twice a day by mouth and XR 150 mg every AM by mouth. Review of the residents MOR dated revealed that his mediations were given as ordered.

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Interview conducted with the Administrator on [redacted] at approximately 2:50 PM who stated that resident #1 was seen by the ARNP who visits the facility on [redacted]. The ARNP did not express any concerns. The facility Administrator stated she paid to buy supplements for resident #1 on [redacted].

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Avalon's Assisted Living II
13230 Early Frost Circle
Orlando, FL 32828

Dear Administrator:

Re: CCR #2013010676

This letter reports the findings of a state licensure 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 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 Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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