STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910716	11/01/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
North Lake Retirement Home	1222 North 16th Avenue Hollywood, FL 33020	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

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 - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt 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 complaint survey, CCR# 2013006089 was conducted on [redacted] and [redacted] at North Lake Retirement Home. The facility had deficiencies found at the time of the visit.

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

Based on observation, interview and record review, the facility failed to provide care and services appropriate to meet the ongoing needs of 2 out of 5 sampled residents. As evidenced by the failure to protect the safety and well-being of Resident #1 and failure to re-evaluate the appropriateness of continued residency for Resident #2.

The findings include:

Resident #1 was admitted to facility on [redacted] with medical conditions including [redacted] slow gait, poor balance, visual [redacted] and [redacted] The resident had been living at home with his family until they were unable to care for him. The Resident Health Assessment form (AHCA 1823 form) dated [redacted] reveals the resident needs assistance with self-administration of medications, needs assistance with all ADL care, and supervision with ambulation and eating. He requires daily observation for his well-being and whereabouts. Review of the [redacted] 2012 Medication Observation Record (MOR) on admission reveals the resident was prescribed [redacted] 10 mg every day and [redacted] 10 mg twice a day for [redacted] and [redacted] 0.5 mg at bedtime for [redacted] On [redacted] the physician/ ARNP discontinued these medications and ordered [redacted] 50 mg by mouth at bedtime. Record review reveals a [redacted] history on [redacted] for which the resident was sent to

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hospital for evaluation, the physician and family were notified at the time.

Resident #2 was admitted to the facility on [redacted] with medical conditions of [redacted] and [redacted]. He was documented on the Admission Health Assessment 1823 form as [redacted] at times, independent for all ADL's except bathing and transferring. He had an unsteady gait requiring supervision with ambulation and used a cane. He required daily oversight for well-being and whereabouts. The resident was documented as a nice and pleasant man on admission, with no history of violence or aggressive behavior noted on the Health Assessment 1823 form. Review of [redacted] 2013 MOR revealed the resident was prescribed [redacted] 5 mg every morning and had an order for [redacted] 0.5 mg twice daily as needed for [redacted] No [redacted] was documented as administered in those months. The resident is documented as demonstrating aggressive behavior by hitting 2 residents, before he was discharged from the facility by his family on [redacted].

Review of the facility incident report reveals that on [redacted] at approximately 9 PM, Resident #1 and Resident #2 had an argument in their [redacted]. The report documents that Resident #1 kept approaching Resident #2's bed and would not move away, Resident #2 then hit Resident #1 with his cane. There were no eye witnesses to the incident, [redacted] and Police were called by staff, the residents families and physician were notified of the incident and Resident #1 was transferred to the ER (Emergency [redacted] and Resident #2 was moved to another [redacted]. Review of the facility notes reveals that resident #1 was readmitted to the facility on [redacted] and was transferred back to the hospital on [redacted] after becoming very [redacted].

Review of hospital records dated [redacted] at 11:30 PM, the Emergency [redacted] Admission record reveals the resident, a male with head [redacted] as result of an assault in the facility. Patient hit on head with [redacted] cane after possible [redacted] on the other person. No apparent injuries were noted anywhere, only [redacted] and [redacted] on head. The findings included: 1 cm superficial laceration on left upper [redacted] and [redacted] on top of head. No other [redacted] noted on body. Negative midline [redacted] or lumbar tenderness noted. No pain of deformity on hips or shoulders. [redacted] assessment revealed normal strength and [redacted]. Patient is disoriented with withdrawn, cognition and memory are [redacted] and he is noncommunicative. A [redacted] without contrast determined acute and chronic left sided [redacted] hematoma with maximal width of the hematoma measuring approximately 1.3 cm. There is a shift associated [redacted] effect with a left to right midline shift of approximately 6.4 mm. The resident was admitted to the [redacted] for [redacted] monitoring. On [redacted] the resident was scheduled for left frontal [redacted] for removal of [redacted] hematoma. The [redacted] Note documents the resident was in the facility for history of aggressive behavior with

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and was in an altercation with another resident. The patient was struck on the head with a cane and then countered back with his walker against the resident. The resident sustained a large left subacute hematoma with causing a large amount of compression of the left hemisphere. There was a lot of subacute and possible acute pushing the away from the dura.The resident was severely but still agitated and moving all four extremities but unable to walk. A repeat showed the getting a little larger. The family was consulted due to the concern of development of The family requested to proceed with removal of the hematoma. were considered but due to the advanced that have formed, a mini was performed. The note documents that the resident had a serious approximately 2 months prior and the did not show any hematoma at that time. The physician guessed that the insidious hematoma developed and now has progressed and getting worse. The benefits and risks were discussed with the family. The residents condition became stable and he was discharged by the neurosurgery team on with a follow-up appointment in a week.

On at 1:40 PM the resident was readmitted to the ER due to resident "acting differently" per staff documentation. On readmission to the ER, the residents vital signs were stable, he was nonverbal, mumbling words and unable to follow commands. He was assessed with left sided large scar with staples in place and old to frontal scalp. Pupils were 3 mm and slowly reactive. The resident was disoriented, displaying no Babinski ' s sign on the right or left side and is generally stiff with decreased range of motion in all joints. A was completed which revealed a mild increase in effect due to mild increase in left convexity hypodense fluid with more recent hyperdense (acute) hematoma (mild rebleed). The resident was readmitted to the for monitoring. Lab results revealed an elevated white count, level and a The plan included to the resident, monitor the hematoma, treatment prophylaxis, and one to one sitter for the resident. Review of discharge summary dated reveals the resident had advanced and poor nutritional intake with the worsening hematoma. The resident was reevaluated by the neurosurgeon who determined the resident was not a good for another operation or further interventions due to advanced and poor state. The note documents the family requested hospice care. The resident was then transferred to in- house hospice services at another hospital, where he days later.

On at approximately 1:30 PM during an interview with an employee who initially responded to the incident on between Resident #1 and #2. She stated that she regularly works the evening/night shift and does rounds every few hours to check on the residents. She stated that there are 2 staff assigned to the shift. She stated that she walked into the resident ' s was dark, she turned on the light and saw Resident #1 covered in She stated that she did not hear any screams

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or yelling prior to entering the . . . . . She stated that Resident #1 was standing in the middle of the . . . . . She stated she immediately went for assistance and to get the phone to call 911 and the police. She stated that Resident #2 kept hitting Resident #1 with his cane even after she had entered the . . . . . She stated that EMT and the police arrived immediately and Resident #1 was transferred to the hospital for treatment. Resident #2 remained at the facility and was questioned by the police. She stated that the night before the incident, she overheard Resident #2 speaking on the phone with his family. He was expressing his concerns about Resident #1's actions at night, wandering in the . . . . . During the interview she recalled she did not tell anyone about the phone call, because she forgot.

On . . . . . at approximately 11:00 AM during an interview with the facility Manager, he stated that the incident on . . . . . was the first between Resident #1 and #2. He stated that the men had been . . . . . for several weeks with no incidents. He stated that he had investigated the incident and had determined that Resident #2 had been asleep and was awakened, alarmed when his . . . . . Resident #1 was standing over him and would not move away. The Manager stated that Resident #1 only spoke Spanish. He stated that Resident #2 yelled to get away in English, therefore Resident #1 did not respond. He stated that Resident #2 hit Resident #1 with his cane numerous times. He stated that neither resident had any history of being aggressive, but both had . . . . . .He stated that Resident #1 was visually . . . . . and would wander in his . . . . . night, reaching for objects. He stated that after the incident, Resident #2 had expressed his concerns that Resident #1 was exhibiting . . . . . behaviors. He stated that the staff had notified him immediately when the incident occurred.

On 11/1/2013 at 2:20 PM a phone interview was conducted with Resident #1' s daughter. She stated that she did not want to get the facility in trouble and that is why she did not press charges with the police against Resident #2. She stated that her father had been living with her, along with his wife and Resident #1 had become more difficult to monitor 24 hours a day. She stated that Resident #1 had . . . . . and suffered from "sundowners . . . . . She stated that her father was a kind gentle man but the . . . . . had taken his memory and he was in a " lost state " most of the time. She stated that her father would wander at night and he could become aggressive when attempts to redirect him were made. She stated that he did not recognize her or his wife at night, he was not in his right mind. She stated that she could understand if Resident #2 had felt threatened, and she could not blame Resident #2 because he also had . . . . . and was . . . . . She stated that she had never met Resident #2. She stated her father required monitoring since he was unable to help himself to eat, toilet or bathe mainly because he did not recall how to help himself. She stated her father had a history of . . . . . prior to admission. She stated that she and her siblings would visit daily at all hours of the day, they would assist the resident with eating his meals. She stated on her fathers admission to the facility, she had asked the Owner/Administrator if the facility could care for her fathers needs and they told her they could. She stated that now looking back at the incident she should have removed her father from

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the facility and placed him into a facility. She stated that she was upset that the facility did not inform her that they could not provide 24 hour monitoring for her father. She stated that accidents occur and she understood but grew concerned that the facility had not been honest with her. She stated that while her father was in the hospital she found a smaller ALF to transfer her father but unfortunately he had a further decline and was placed on hospice services. She stated that he about 5 days after being admitted to hospice. She stated that she had discussed her father ' s monitoring care with the Assistant Administrator numerous times and she stated she was reassured that her father was being cared for. She stated that the father needed to be in a facility and she now feels guilty that she did not recognize the abilities/differences in facilities.

On at approximately 12:00 PM during an interview with the Assistant Administrator, he confirmed Resident #1 had and required monitoring and direction from the staff. He stated that Resident #2 had not been evaluated at time of his admission, to be a violent man by the physician. The Assistant Administrator stated that after the incident on Resident #2 had not been reevaluated by the medical physician to determine if the resident was a danger to himself or other residents. He stated that the facility moved Resident #2 to another he had no further contact with Resident #1. He stated that neither he nor his manager had any indication of any behaviors for either resident. Furthermore, he confirmed that there had been another incident involving Resident #2 on He stated after that incident, Resident #2 was removed from the facility by his family. He concluded that he may have to screen resident admissions more thoroughly as a result of this investigation.

Further review of the facility incident reports, dated reveals Resident #2 was in the dining approximately 8:30 AM when he spotted Resident #3 wearing his baseball cap. Resident #2 approached Resident #3, swore at him and then punched Resident #3. Resident #3 is documented as punching back, 3 times. The facility staff witnessed the incident and broke up the fight. The report documents that Resident #3 had purchased the cap from Resident #2 ' s previous Both residents declined to be sent to the ER for evaluation. The facility documents that they would keep residents away from each other to avoid other incidents. Resident #2 daughter was notified of the incident. Review of the facility notes dated reveals Resident #2 suffered a scratch to the nose from his glasses, with no other apparent injuries and the resident had no change in condition for the remainder of day. On the facility note documents discoloration around resident #2 's eye. The resident requested to speak with his daughter, she arrived at the facility and removed him.

Resident #3 was admitted to the facility with medical conditions of and He is documented as alert, easy irritable,

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argumentative at times and demanding. The 1823 form on admission documents the resident as independent for all ADL care, only supervision with . He requires weekly oversight and is able to make own phone calls, and requires supervision with personal affairs.

On at approximately 2:45 PM during an interview with Resident #3 he confirmed the account of the incident that occurred on . He stated that he had purchased the baseball cap from resident #2 ' s prior for $14 dollars. He stated that Resident #2 did not want him to wear the cap. He stated that he had offered to give the cap back to Resident #2 but he declined. He stated that he told Resident #2 he was a " nasty b---h- " because he refused to take the cap back. He stated that he was minding his own business, eating his breakfast, when Resident #2 hit him in the head. He stated he punched Resident #2, three times before the staff broke up the fight. He stated that he was not injured and refused to go to the ER.

On at 10:45 AM an interview was conducted with Resident's #3 The resident stated that he could not recall Resident #1, but he remembers Resident #2 because Resident #2 gave him the baseball cap. The resident stated that Resident #2 was not an aggressive person but had a "macho" attitude. He stated that Resident #2 did not appreciate that his cap was being worn by Resident #3. The resident stated that he did not witness the fight between Resident #3 and Resident #2 but learned of it from Resident #3. He stated that he could not recall any other incidents or fights between Resident #2 and any another residents.

Class III

Cross reference to A0025 and A0165

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

Based on observation, interview and record review, the facility failed to provide care and services appropriate to meet the needs of 3 out of 5 sampled residents. As evidenced by the failure to have awareness/knowledge that a resident had developed a failure to properly inform and document a significant change in condition, failure to reassess on readmission for care treatments and failure to provide required ongoing nursing assessment/ monitoring of a foot for Resident # 4 and failure to protect the safety and well-being of Resident #1 and Resident #3 who were both involved in an altercation with Resident #2 on two separate occasions.

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The findings include:

1). Resident #4 was admitted to the facility on with and The admission 1823 dated reveals the resident is independent for ADL care except requiring supervision with and she requires daily observation of her whereabouts and well being. She needs assistance with medication self administration.

On at approximately 11:45 AM an observation was made of the resident's the facility Manager. The resident was observed lying in her bed, she stated that she was "not feeling great due to pain in her right foot". She stated that she had and broken her right foot. She stated that she had an open on her foot which the physician described as "nasty". She stated that she is on for in her foot and inquired to the Manager that she needed to soak her foot per physician instructions. The Manager stated he would buy for her. The resident removed the bed sheet to reveal her right foot wrapped in an wrinkled bandage with a hard under her foot/ sole. Her toes were discolored, purple and bluish. She stated that she was in pain and "only with sleep, does the pain subside". She stated that she had been seen by the orthopedic physician a few days earlier and was not allowed to bear weight on the foot. She stated that she had been seen by a Home Health Nurse a few times to check her foot, but had not seen the nurse since the was identified. She stated that she needs assistance showering because she must keep the bandages dry. The Facility Manager stated that he was unaware that she had an open on her foot. He stated that he was unaware if the Home Health Nurse had been visiting the resident.

Review of the facility Incident Report,dated reveals Resident #4 was found outside her on the ground. The report documents the resident lost her balance while using her walker and She complained of pain in her right foot and was sent to the ER for evaluation. The family and physician were notified of the incident.

Review of the Discharge Instructions from the hospital,dated reveals care instructions for the or The instructions include get help right away if pain is not relieved with medication, if pain does not get better within a week, the toe is when others are warm, if loss of feeling or turns white/red.

Review of the Admission Consent from the Home Health Agency, dated reveals an order for Skilled Nursing to evaluate and complete 3 visits. Review of the Communication Sheet from the Home Health Nurse reveals on , the resident was evaluated and an assessment was completed. The note documents a in place on the right foot and ice packs were being applied. The note

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documents the resident complaining of pain in the foot and medication was administered. On , the note reveals the right foot has a large and the resident continues to complain of pain. The note documents the resident had a scheduled physician appointment later on that day and the nurse instructed the resident, that she must see the physician to evaluate the . On , the note reveals the is open and the resident had not seen the physician due to referral paperwork issues. The Home Health Nurse informed the facility that the resident must be sent to the hospital for evaluation of the .
Review of the facility Progress Note, dated , reveals the Home Health Nurse informed the facility that the resident had a under the temporary , and the resident was sent out for evaluation.

Review of the Hospital Emergency order dated , reveals the resident has of the foot and to return within 24-48 hours for check. The resident was prescribed 875 mg by mouth twice a day and DS 2 times a day by mouth. The discharge instructions for include take prescribed medications as prescribed, keep leg elevated, seek medical care if area of spreads, pain worsens, and development of pain or .
Review of the 2013 Medication Observation Record reveals the prescribed were started on .

Review of the Orthopedic Physician note dated , reveals the resident had injury to the right foot, with a which popped. The resident was placed on . The examination reveals the right foot has soft tissue but the compartments are soft compressible. There is with no gross purulence area and pain over second base. The Assessment includes crushing injury of right foot. The note reveals the patient needs management and management of . Continue on with follow-up weight bearing x-rays of foot in 1 week.

On at approximately 2:00 PM during a further interview with the Facility Manager, he stated that he was not aware that the resident had developed a and . He stated that the facility does not have nurses on staff to assess and monitor the condition of the residents foot. He confirmed that the facility does not have an Limited Nursing License allowing for care of a . He stated that Home Health nurses must provide the necessary treatments. He stated that he was unaware of any orders from the physician regarding monitoring or care. He acknowledged that the resident's foot required monitoring by appropriate personnel. He stated he would call the physician to inquire about orders for the Home Health nurse to monitor and provide care to the foot.

On at approximately 2:30 PM during an interview with the Administrator, he stated that he

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had transported Resident #4 to the physician appointments but was unaware she had developed a or in the foot.

2). Resident #1 was admitted to facility on with medical conditions including , slow gait, poor balance, visual and . The resident had been living at home with his family until they were unable to care for him. The Resident Health Assessment form (AHCA 1823 form) dated reveals the resident needs assistance with self-administration of medications, needs assistance with all ADL care, and supervision with ambulation and eating. He requires daily observation for his well-being and whereabouts. Review of the 2012 Medication Observation Record (MOR) on admission reveals the resident was prescribed 10 mg every day and 10 mg twice a day for and 0.5 mg at bedtime for . On the physician/ ARNP discontinued these medications and ordered 50 mg by mouth at bedtime. Record review reveals a history on for which the resident was sent to hospital for evaluation, the physician and family were notified at the time.

Resident #2 was admitted to the facility on with medical conditions of and He was documented on the Admission Health Assessment 1823 form as at times, independent for all ADL's except bathing and transferring. He had an unsteady gait requiring supervision with ambulation and used a cane. He required daily oversight for wellbeing and whereabouts. The resident was documented as a nice and pleasant man on admission, with no history of violence or aggressive behavior noted on the Health Assessment 1823 form. Review of and 2013 MOR revealed the resident was prescribed 5 mg every morning and had an order for 0.5 mg twice daily as needed for No was documented as administered in those months. The resident is documented as demonstrating aggressive behavior by hitting 2 residents, before he was discharged from the facility by his family on .

Review of the facility incident report reveals that on at approximately 9 PM, Resident #1 and Resident #2 had an argument in their . The report documents that Resident #1 kept approaching Resident #2's bed and would not move away, Resident #2 then hit Resident #1 with his cane. There were no eye witnesses to the incident, and Police were called by staff, the residents families and physician were notified of the incident and Resident #1 was transferred to the ER (Emergency and Resident #2 was moved to another . Review of the facility notes reveals that Resident #1 was readmitted to the facility on and was transferred back to the hospital on after becoming very .

Review of hospital records dated at 11:30 PM, the Emergency Admission record reveals the resident (Resident #1), a male with head as result of an assault in the facility.

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Patient hit on head with cane after possible on the other person. No apparent injuries were noted anywhere, only and on head. The findings included: 1 cm superficial laceration on left upper and on top of head. No other noted on body. Negative midline or lumbar tenderness noted. No pain of deformity on hips or shoulders. assessment revealed normal strength and Patient is disoriented with withdrawn, cognition and memory are and he is noncommunicative. A without contrast determined acute and chronic left sided hematoma with maximal width of the hematoma measuring approximately 1.3 cm. There is a shift associated effect with a left to right midline shift of approximately 6.4 mm. The resident was admitted to the for monitoring. On the resident was scheduled for left frontal for removal of hematoma. The Note documents the resident was in the facility for history of aggressive behavior with and was in an altercation with another resident. The patient was struck on the head with a cane and then countered back with his walker against the resident. The resident sustained a large left subacute hematoma with causing a large amount of compression of the left hemisphere. There was a lot of subacute and possible acute pushing the away from the dura.The resident was severely but still agitated and moving all four extremities but unable to walk. A repeat showed the getting a little larger. The family was consulted due to the concern of development of The family requested to proceed with removal of the hematoma. were considered but due to the advanced that have formed, a mini was performed. The note documents that the resident had a serious approximately 2 months prior and the did not show any hematoma at that time. The physician guessed that the insidious hematoma developed and now has progressed and getting worse. The benefits and risks were discussed with the family. The residents condition became stable and he was discharged by the neurosurgery team on with a follow-up appointment in a week.

On at 1:40 PM Resident #1 was readmitted to the ER due to resident "acting differently" per staff documentation. On readmission to the ER, the residents vital signs were stable, he was nonverbal, mumbling words and unable to follow commands. He was assessed with left sided large scar with staples in place and old to frontal scalp. Pupils were 3 mm and slowly reactive. The resident was disoriented, displaying no Babinski ' s sign on the right or left side and is generally stiff with decreased range of motion in all joints. A was completed which revealed a mild increase in effect due to mild increase in left convexity hypodense fluid with more recent hyperdense(acute) hematoma (mild rebleed). The resident was readmitted to the for monitoring. Lab results revealed an elevated white count, level and a The plan included to the resident, monitor the hematoma, treatment prophylaxis, and one to one sitter for the resident. Review of discharge summary dated

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reveals the resident had advanced and poor nutritional intake with the worsening hematoma. The resident was reevaluated by the neurosurgeon who determined the resident was not a good for another operation or further interventions due to advanced and poor state. The note documents the family requested hospice care. The resident was then transferred to in- house hospice services at another hospital, where he days later.

On at approximately 1:30 PM during an interview with an employee who initially responded to the incident on between Resident #1 and #2. She stated that she regularly works the evening/night shift and does rounds every few hours to check on the residents. She stated that there are 2 staff assigned to the shift. She stated that she walked into the resident ' s was dark, she turned on the light and saw Resident #1 covered in . She stated that she did not hear any screams or yelling prior to entering the . She stated that Resident #1 was standing in the middle of the . She stated she immediately went for assistance and to get the phone to call 911 and the police. She stated that Resident #2 kept hitting Resident #1 with his cane even after she had entered the . She stated that EMT and the police arrived immediately and Resident #1 was transferred to the hospital for treatment. Resident #2 remained at the facility and was questioned by the police. She stated that the night before the incident, she overheard Resident #2 speaking on the phone with his family. He was expressing his concerns about Resident #1's actions at night, wandering in the . During the interview she recalled she did not tell anyone about the phone call, because she forgot.

On at approximately 11:00 AM during an interview with the facility Manager, he stated that the incident on was the first between Resident #1 and #2. He stated that the men had been for several weeks with no incidents. He stated that he had investigated the incident and had determined that Resident #2 had been asleep and was awakened, alarmed when his Resident #1 was standing over him and would not move away. The Manager stated that Resident #1 only spoke Spanish. He stated that Resident #2 yelled to get away in English, therefore Resident #1 did not respond. He stated that Resident #2 hit Resident #1 with his cane numerous times. He stated that neither resident had any history of being aggressive, but both had .He stated that Resident #1 was visually and would wander in his night, reaching for objects. He stated that after the incident, Resident #2 had expressed his concerns that Resident #1 was exhibiting behaviors. He stated that the staff had notified him immediately when the incident occurred.

3). Further review of the facility incident reports, dated reveals Resident #2 was in the dining approximately 8:30 AM when he spotted Resident #3 wearing his baseball cap. Resident #2 approached Resident #3, swore at him and then punched Resident #3. Resident #3 is documented as punching back, 3 times. The facility staff witnessed the incident and broke up the fight. The report documents that Resident #3 had purchased the cap from Resident #2 ' s previous Both

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residents declined to be sent to the ER for evaluation. The facility documents that they would keep residents away from each other to avoid other incidents. Resident #2 daughter was notified of the incident. Review of the facility notes dated reveals Resident #2 suffered a scratch to the nose from his glasses, with no other apparent injuries and the resident had no change in condition for the remainder of day. On the facility note documents discoloration around Resident #2 's eye. The resident requested to speak with his daughter, she arrived at the facility and removed him.

Resident #3 was admitted to the facility with medical conditions of and He is documented as alert, easy irritable, argumentative at times and demanding. The 1823 form on admission documents the resident as independent for all ADL care, only supervision with He requires weekly oversight and is able to make own phone calls, and requires supervision with personal affairs.

On at approximately 2:45 PM during an interview with Resident #3 he confirmed the account of the incident that occurred on He stated that he had purchased the baseball cap from Resident #2 ' s prior for $14 dollars. He stated that resident #2 did not want him to wear the cap. He stated that he had offered to give the cap back to Resident #2 but he declined. He stated that he told Resident #2 he was a " nasty b---h- " because he refused to take the cap back. He stated that he was minding his own business, eating his breakfast, when Resident #2 hit him in the head. He stated he punched Resident #2, three times before the staff broke up the fight. He stated that he was not injured and refused to go to the ER.

On 11/1/2013 at 2:20 PM a phone interview was conducted with Resident #1' s daughter. She stated that she did not want to get the facility in trouble and that is why she did not press charges with the police against Resident #2. She stated that her father had been living with her, along with his wife and Resident #1 had become more difficult to monitor 24 hours a day. She stated that Resident #1 had and suffered from "sundowners She stated that her father was a kind gentle man but the had taken his memory and he was in a " lost state " most of the time. She stated that her father would wander at night and he could become aggressive when attempts to redirect him were made. She stated that he did not recognize her or his wife at night, he was not in his right mind. She stated that she could understand if Resident #2 had felt threatened, and she could not blame Resident #2 because he also had and was She stated that she had never met Resident #2. She stated her father required monitoring since he was unable to help himself to eat, toilet or bathe mainly because he did not recall how to help himself. She stated her father had a history of prior to admission. She stated that she and her siblings would visit daily at all hours of the day,

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they would assist the resident with eating his meals. She stated on her fathers admission to the facility, she had asked the Owner/Administrator if the facility could care for her fathers needs and they told her they could. She stated that now looking back at the incident she should have removed her father from the facility and placed him into a facility. She stated that she was upset that the facility did not inform her that they could not provide 24 hour monitoring for her father. She stated that accidents occur and she understood but grew concerned that the facility had not been honest with her. She stated that while her father was in the hospital she found a smaller ALF to transfer her father but unfortunately he had a further decline and was placed on hospice services. She stated that he about 5 days after being admitted to hospice. She stated that she had discussed her father ' s monitoring care with the Assistant Administrator numerous times and she stated she was reassured that her father was being cared for. She stated that the father needed to be in a facility and she now feels guilty that she did not recognize the abilities/differences in facilities.

On at approximately 12:00 PM during an interview with the Assistant Administrator, he confirmed Resident #1 had and required monitoring and direction from the staff. He stated that Resident #2 had not been evaluated at time of his admission, to be a violent man by the physician. The Assistant Administrator stated that after the incident on , Resident #2 had not been reevaluated by the medical physician to determine if the resident was a danger to himself or other residents. He stated that the facility moved Resident #2 to another he had no further contact with Resident #1. He stated that neither he nor his manager had any indication of any behaviors for either resident. Furthermore, he confirmed that there had been another incident involving Resident #2 on . He stated after that incident, Resident #2 was removed from the facility by his family. He concluded that he may have to screen resident admissions more thoroughly as a result of this investigation.

Class III

Cross reference to A0010 and A0165

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC

Based on observation, record review and interviews, it was determined that the facility failed to ensure staff provided assistance with self-administration of medications to all residents that required medication assistance as physician ordered, for 1 of 5 sampled residents (Resident #4).

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The findings include:

Resident #4 was admitted with and . The admission 1823 dated reveals the resident is independent for ADL care except for supervision with . She requires daily observation of her whereabouts and well being. She needs assistance with self medication administration.

On at approximately 11:45 AM an observation was made of the residents the facility Manager. On the residents bedside table was a with tubing attached, along with medications including a box of 0.083% vials and a box of 0.02% vials. The resident who is alert and oriented, stated that she self- administers the medications as she needs them. She could not recall when she had used them last.

Review of the 2013 Medication Observation Record (MOR) reveals the resident has been self - administering prescribed inhaler daily, inhaler daily, 0.083% via and 0.025 via No documentation was noted on the MOR as to when the resident had received these medications.

An interview was conducted with the Manager on at 12:31 PM, he reviewed the 1823 form and acknowledged that the physician had ordered that medications require assistance with self administration for the resident. The Manager stated that the resident has been administering her own medications. He stated he would contact the physician to have the orders for the treatments changed to reflect the curent practice.

Class III

0054-Medication - Records 58A-5.0185(5) FAC

Based on observation,interview and record review the facility failed to accurately document all medications given as evidenced by the omission of signatures/initials that medications are given on the Medication Observation Record for 1 of 5 sampled residents (Resident #5).

The findings include:

Resident #5 has medical history including and ı.Review of the 2013 Medication Observation Record for the Resident #5 reveals the lack of signature

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documentation for 3 medications that are prescribed to be administered on at bedtime. The medications included and

On at approximately 2:45 PM during an interview with the Assistant Administrator, she stated that the medication aide must have forgotten to sign off on the record and that the medications were administered on

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC

Based on record review and interview, the facility failed to ensure that employees had the required in-service training for 2 out of 7 sampled Employees (Employee #1 and #2).

The findings include:

During a review of the employee files, the following was noted:
1. Employee #1, an aide, was hired on had no documentation of in-service training for resident rights and recognizing and reporting neglect and within 30 days of hire.
2. Employee #2, an aide, was hired on had no documentation of in-service training for resident rights and recognizing and reporting neglect and Also no documentation of training for reporting adverse incidents within 30 days of hire.

The Assistant Administrator was interviewed on at 2:00PM and no additional information was provided.

Class III

0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC

Based on record review and interview, the facility failed to ensure that employees had received the required training for the annual 2 hour continuing education training on providing assistance with self-administered medications for 3 of 7 sampled employees (Employee #2, #6 and #7).

The findings include:

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During a review of the employee files, it was noted that Employee #2, #6 and #7 had no documentation of the required 2 hours of continuing education on providing assistance with medications in the past 12 months. The employees job responsibility includes providing assistance with self-administered medications to residents.

The Assistant Administrator was interviewed on at 2:00 p.m. and no additional information was provided.

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 follow the established risk management and quality assurance program by the failure to submit the required adverse incident report after an event occurred.

The findings are:

Resident #1 was admitted to the facility on with medical conditions including slow gait, poor balance, vision and The Admission Resident Health Assessment form 1823 dated reveals the resident required assistance with self -administration of medications, and with ADL care. He required supervision with ambulation and eating also daily observation for well-being and whereabouts. The resident did not speak English. Record review reveals the resident had a history of a on and was sent to hospital for evaluation, physician and family were notified and he was readmitted the same day.

Resident #2 was admitted to facility on with medical conditions including and He was documented on the admission health assessment form 1823, as at times. He was independent for all ADL's except bathing and transferring. He had an unsteady gait requiring supervision with ambulation. He required daily oversight for wellbeing and whereabouts.

Further review of the facility incident report reveals on at approximately 9 PM, Resident #1 and Resident #2 had an argument. The report documents that Resident #1 kept approaching Resident

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#2's bed in the darkened ... would not move away when Resident #2 yelled at him. Resident #2 hit Resident #1 with his cane. There were no eye witnesses to the incident. ... and Police were called by the staff. The resident' s family and physician were notified of the incident and the resident was transferred to the ER. Resident #2 was moved to another ...

On ... at approximately 1:30 PM during an interview with the staff member who initially responded to the incident on ... between Resident #1 and Resident #2, she stated that she routinely works the evening/ night shift and completes her rounds every few hours to check on the residents. She stated that she walked into the residents ... was dark, she turned on the light and saw Resident #1 covered in ... She stated that she did not hear any screams or yelling prior to entering the ... She stated that Resident #1 was standing in the middle of the ... She stated that she immediately went for assistance and to get the phone to call 911 and the police. She stated that Resident #2 kept hitting Resident #1 with his cane even after she had entered the ... directed him to stop. She stated that the EMT and the police arrived immediately and Resident #1 was transferred to the hospital for treatment. Resident #2 remained and was questioned by the police. She stated that on the previous night before the incident, Resident #2 had phoned his family and expressed his concerns about Resident #1 ' s actions toward him and his wandering around the ... She stated she did not tell anyone about the phone call.

On ... at approximately 11:00 AM during an interview with the Manager, he stated that the incident on ... between Resident #1 and #2 was the first. He stated that the men had been ... for several weeks with no incidents. He stated that he had investigated the incident and had determined that Resident #2 had been asleep and was awakened alarmed when his ... Resident #1 was standing over him and would not move away. The Manager confirmed Resident #1 only spoke Spanish . He stated that Resident #2 yelled to get away in English and therefore Resident #1 did not respond. He stated that Resident #2 hit Resident #1 numerous times with his cane. He stated that Resident #1 and #2 had no history of being aggressive, but both had ... He stated that Resident #1 was visually ... and would wander in his ... reaching for things. He stated that Resident #2 had expressed his concerns after the incident stating Resident #1 was ... aggressive to him and he felt threatened. He stated that the staff had notified him when the incident occurred. He stated that he had not submitted a 1 day report for Adverse Incident to AHCA.

On ... at approximately 2:30 PM during an interview with the Administrator, he acknowledged that the facility had failed to submit the required 1 day Adverse Incident report to AHCA.

Review of the facility notes reveals that Resident #1 was readmitted to the facility on

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and was transferred back to the hospital on after experiencing a change in mental condition.

Class III

Cross reference to A0010 and A0025

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
North Lake Retirement Home
1222 North 16th Avenue
Hollywood, FL 33020

RE: CCR #2013006089

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on .2013 and 1, 2013 by a representative 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 **2014** 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,

for Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

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