STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964810	03/06/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Conway	5501 East Michigan Street Orlando, FL 32822	
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 - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0082 - 58a-5.0191(3) Fac - Training - [redacted] S-S= D
St - A - 0086 - 58a-5.0191(9) Fac - Training - Adrd S-S= D
St - A - 0090 - 58a-5.0191(11) Fac - Training - [redacted] 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
A complaint inspection CCR2013012984 was conducted on [redacted]

Emeritus at Conway had deficiencies found at the time of the survey.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on interviews and record review the facility failed to provide care and services appropriate to the need of 1 of 4 sampled residents (#1) and failed to ensure transfers were per resident's service plan, safely and without injury.

Findings:

Resident record review on [redacted] at approximately 11:30 AM for resident #1 revealed a health assessment report dated [redacted] 2012. The assessment indicated diagnoses of [redacted] left extremity [redacted] insufficiency and decreased sensation in feet. She used a walker to ambulate; assistance was needed with all the activities of daily living. According to the assessment the resident tired easily.

The individualized service plan dated [redacted] indicated the resident used a walker and a wheelchair; was forgetful and required stand by assistance with toileting and was independent with transfers.

The bi-annual assessment indicated a change in level of care; the resident needed increased assistance with ADL's, since the last review. The resident assist with transfers has increased

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to 2 (staff). The left bottom of the page indicated 7:30 AM. The next assessment was due

Telephone order dated requested Physical /Occupational /Skilled Nursing related to difficulty with transfers. The physician approved the request. Another order dated requested a bed for transfers. Physician's order for hospital bed.

Incident report dated indicated that at approximately 5:40 AM the caregiver (G) reported that while transferring resident #1 to the , residents legs became weak and she lost her balance. Staff G lowered resident #1to the floor. The interventions /corrective measures to be implemented was to re-educated the staff that the resident was a 2 person assist, not one. The resident went to the hospital with " outcome". The resident was a level 5 of care. The event management report dated indicated staff A attempted to transfer resident alone, the resident panicked, stated her legs got weak and gave in , he lowered her to the floor to prevent injury. The "resident stated he dropped her, not understanding he lowered her to prevent injury". Resident went to the emergency , daughter reported sustained two from In a statement given by staff to the facility he indicated he put the resident on the floor because she was closer to floor than to the bed, and went to get co-worker. When they returned and turned on the light " I saw her leg twisted and we call 911".

Facility note dated 9 AM indicated that caregivers complaint they were unable to lift resident #1 with one person only. " Staff educated about lifting with 2 people " .

Facility note dated 4 PM indicated "resident attendants and myself had a difficult time lifting resident. It took 3 people to transfer her and about 45 minutes to transfer her. We had to put her in her chair with her feet up because they looked

Facility note dated 10 AM indicated "had 3 people to help assist resident during transfers. Very hard to transfer, still no use of [illegible] board".

Facility note dated 10:15 AM Resident was difficult to transfer even with 3 people assisting.

Facility note dated 2 PM was informed resident was in hospital.

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Facility note dated 10 AM Called hospital and was informed the resident had a on each leg; one is on the

Facility note dated 4 PM called hospital to inquire about resident ,but no information was obtained. The note continued, it indicate the writer spoke with staff G, who stated he knew the resident needed 2 people to assist but decided to attempt the transfer on his own. He tried to transfer her by sitting her on side of the bed and transfer to wheelchair that was close by. The resident changed her mind and asked to be transferred back to bed. Both of them lost balance and he lowered her to the floor to avoid potential but instead, she complaint of discomfort and pain. The family and 911 were called.

On there was a 1 hour staff meeting where ergonomics (work place safety)/transfers were reviewed. A Physical conducted the training. Staff G did not attend meeting. was doing individual training with the staff but the staff involved with resident #1 had not attended.

In an interview with the executive director on at approximately 4 PM he offered no comment.

In an interview with staff #G on at approximately 8 AM, he stated, "I do normally by myself. I take her from the bed to I think she was not familiar with people of my color. She did not relate to me the same she related to caucasian. Very demanding, could not satisfy her. I was about to finish and go home. I heard the call bell, my mind told me not to go but I did. The told me resident #1 wanted to go to the in a demanding matter. I cannot remember if the lamp was on or not. Resident #1 was mumbling, crying maybe not wanting me close to her. She did not want me to change her. I asked if she was in pain. I had my hands under her arm pits. She was whining, she was losing her body. I was bearing her weight. I cannot put back in bed because the bed was higher than the chair. She was half way on her knees. I thought to lower to floor. I went to get a co-worker to put her back in chair. When I came back I noticed the leg was not in proper position. So we called 911. "I just did by myself (transferred)". I believe I had the walkie talkie- there was no response so I walked to get somebody.

Review on at approximately 3 PM of the Orlando Fire Department report dated indicated a call was received about a victim. The staff stated they were helping

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the resident to the [redacted] she [redacted] The resident stated she experienced pain of 10 in a scale from 1 to 10. The impression was [redacted] injury. Left leg [redacted]

Review on [redacted] at approximately 4 PM of the hospital record revealed she was admitted with a [redacted] displaced right femur and a left tibular [redacted] after sustaining a [redacted] On [redacted] she underwent surgery to repair the [redacted] She was pronounced [redacted] on [redacted] at 11:29 PM.

Class II

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observations and interview the facility failed to ensure that centrally stored medications were secure at all times.

Findings:

Observations on [redacted] at approximately 10 AM in the memory care unit noted the medication cart was not locked. The cart was located in an open area within the unit. In an interview with staff #F on [redacted] at approximately 10 AM who stated she got distracted.

During an interview with the executive director on [redacted] at approximately 3 PM no comment was offered relating to the unsecured medication cart.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on personnel record review and interview the facility failed to ensure 2 of 3 newly hired staff (G & I) submitted a statement from a health care provider, based on an examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable [redacted] including [redacted] within thirty days of hire.

Findings:

Personnel record review on [redacted] at approximately 9:30 AM revealed the following:

1. Staff G was hired on [redacted] had no evidence to confirm he was free from communicable [redacted] including [redacted] He had a [redacted] monitoring form dated [redacted] that indicated he was

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positive for and was treated in 2001; the form was signed by the staff.

2. Staff I was hired on had no evidence to confirm she was free from communicable including She had a monitoring form dated ; the form was signed by the staff.

In an interview with the business office manager on at approximately 10 AM, who stated the staff filed out the form and he did not know. She was unable to produce the documentation to confirm freedom from communicable including for staff #G and #I.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on personnel record review and interview the facility failed to ensure 3 of 3 sampled staff records contained evidence to confirm the mandated in-service training within 30 days of employment for staff G, H & I.

Findings:

Personnel record review on at approximately 9:30 AM revealed that:

1. Staff G was hired on and was a CNA. Continued review revealed no evidence to confirm he received an in-service training regarding the facility's resident elopement response policies and procedures; 1 hour in-service training regarding the facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation: 1 hour in-service training regarding incidents and adverse reporting:1 hour in-service training regarding resident's rights and recognizing neglect and and 1-hour-in-service training in safe food handling practices.

2. Staff H was hired on Continued review revealed no evidence to confirm she received a 1 hour in-service training regarding the facility's elopement policies and procedures, 1 hour in-service training regarding incidents and adverse reporting; in-service training regarding the facility's resident elopement response policies and procedures; 1-hour-in-service training in safe food handling practices within 30 days of hire. In addition there was no evidence to confirm she received a 3 hour in-service training regarding Activities

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of Daily Living (ADL) and behavior needs. Continued review revealed she was not a Home Health Aide (HHA), Certified Nursing Assistant (CNA) or nurse, therefore exempt from the Activities of Daily Living ADL) and behavior needs.

3. Staff I was hired on . Continued review revealed no evidence to confirm she received: in-service training regarding the facility's resident elopement response policies and procedures:1-hour-in-service training in safe food handling practices: 1 hour in-service training regarding the facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation: 1 hour in-service training regarding incidents and adverse reporting; 1 hour in-service training regarding resident's rights and recognizing , neglect and . She had no evidence to confirm a-1 hour in-serve training regarding) control and 3 hour in-service training regarding Activities of Daily Living (ADL) and behavior needs. Continued review revealed she was not a Home Health Aide, Certified Nursing Assistant or nurse, therefore exempt from the Activities of Daily Living ADL) and behavior needs and) control.

In an interview with the executive director and the business office manager on at approximately 10 AM, who stated the staff were to take the in-services electronically and would like the opportunity to locate the certificates of training. The opportunity was provided. At approximately 11 AM the business office manager stated she needed more time as she needed to contact the cooperate office because of technical issues.

The facility was given the opportunity to submit the certificates electronically via electronic mail (e-mail) by the close of business. The certificates were not received.

Class III

0082-Training - : 58A-5.0191(3) FAC
Based on personnel record review and interview the facility failed to ensure 2 of 3 sampled staff (G & I) records contained evidence to confirm a one- time training regarding)

Findings:

Personnel record review on at approximately 9:30 AM revealed the following:

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1. Staff G hired on [redacted] revealed no evidence to confirm she received one-time training regarding [redacted]

2. Staff I hired [redacted] revealed no evidence to confirm she received a one-time training regarding [redacted]

In an interview with the executive director and the business office manager on [redacted] at approximately 10 AM, who stated the staff were to take the in-services electronically and would like the opportunity to locate the certificates of training. The opportunity was provided. At approximately 11 AM the business office manager stated she needed more time as she needed to contact the cooperate office because of technical issues.

The facility was given the opportunity to submit the certificates electronically via electronic mail (e-mail) by the close of business. The certificates were not received.

Class III

0086-Training - ADRD 58A-5.0191(9) FAC
Based on personnel record review and interview the facility, who maintained a secure memory care area, failed to ensure that 1 of 3 sampled staff (G) who had only incidental contact with residents with [redacted] or Related [redacted] (ADRD) received general written information provided by the facility on interacting with such residents, as required under Section 429.178, F.S., within three (3) months of employment.

Findings:

Personnel record review on [redacted] at approximately 9:30 AM revealed staff G was hired on [redacted]. Continued review revealed no evidence to confirm he received general written information provided by the facility on interacting with residents afflicted with ADRD.

In an interview with the executive director on [redacted] at approximately 10 AM who stated staff G was not assigned to work in the memory care unit, but would have incidental contact with the residents. The business office manager on [redacted] at approximately 10 AM who stated the staff were to take the in-services electronically and would like the opportunity to locate the

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certificates of training. The opportunity was provided. At approximately 11 AM the business office manager stated she needed more time as she needed to contact the cooperate office because of technical issues.

The facility was given the opportunity to submit the certificates electronically via electronic mail (e-mail) by the close of business. The certificates were not received.

Class III

0090-Training - 58A-5.0191(11) FAC
Based on interview and personnel record review the facility failed to provide or arrange for 2 of 3 sampled staff (H & I) to attend at least one hour of training in the facility's policies and procedures regarding

Findings:

Personnel record review on at approximately 9:30 AM revealed that:

1. Staff H was hired on Continued review revealed no evidence to confirm she received a 1 hour in-service training regarding facility's policies and procedures regarding

2. Staff I was hired Continued review revealed no evidence to confirm she received a 1 hour in-service training regarding facility's policies and procedures regarding

In an interview with the executive director and the business office manager on at approximately 10 AM, who stated the staff were to take the in-services electronically and would like the opportunity to locate the certificates of training. The opportunity was provided. At approximately 11 AM the business office manager stated she needed more time as she needed to contact the cooperate office because of technical issues.

The facility was given the opportunity to submit the certificates electronically via electronic mail (e-mail) by the close of business. The certificates were not received.

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0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on resident record and facility record review an interview the facility failed to submit to the Agency the 1 day and 15 day adverse report for 1 of 4 residents.

Findings:

Resident record review at approximately 11:30 AM revealed a facility note dated 2 PM the resident was in the hospital. Facility note dated 10 AM Called hospital and was informed the resident had a on each leg; one is on the Facility note dated 4 PM called hospital to inquire about resident, but no information was obtained. The note indicated the writer spoke with staff G, who stated he knew the resident needed 2 people to assist but decided to attempt the transfer on his own. He tried to transfer her by sitting her on side of the bed and transfer to wheelchair that was close by. The resident changed her mind and asked to be transferred back to bed. Both of them lost balance and he lowered her to the floor to avoid potential but instead, she complained of discomfort and pain. The family and 911 were called.

Review on at approximately 3 PM of the Orlando Fire Department report dated indicated a call was received about a victim (resident #1). The staff stated they were helping the resident to the she The resident stated she experienced pain of 10 in a scale from 1 to 10. The impression was injury, left leg

During an interview with staff G on at approximately 8 AM, he stated, "I do normally (transfer) by myself. I take her from the bed to I think she was not familiar with people of my color. She did not relate to me the same she related to Caucasian. The resident was very demanding, could not satisfy her. I was about to finish and go home. I heard the call bell, my mind told me not to go but I did. The told me resident #1 wanted to go to the in a demanding matter. I cannot remember if the lamp was on or not. Resident #1 was mumbling, crying maybe not want me close to her. She did not want me to change her. I asked if she was in pain. I had my hands under her arm pits. She was whining; she was losing her body. I was bearing her weight. I cannot put back in bed because the bed was higher than the chair. She was half way on her knees. I thought to lower to floor. I went to get a co-worker to put her back in chair. When I came back I noticed the leg was not in the proper position. So we called 911. I just did by myself (transferred). I believe I had the

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walkie-talkie there was no response so I walked to get somebody".

Review of the facility adverse report binder dated 2014 revealed that an adverse report for the event on [redacted] with resident #1 was not available.

In an interview on [redacted] at approximately 12 PM, with the executive director who stated the previous resident care director said she was unable to submit the report, either because technical difficulties or something to do with the password, evidently she did not submit the reports.

Class III

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Emeritus At Conway
5501 East Michigan Street
Orlando, FL 32822

Dear Administrator:

Re: CCR #2013012984

This letter reports the findings of a complaint investigation survey that was conducted on , 2014 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 **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 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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