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	AL11966665	10/24/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Avalon's Assisted Living	1250 Willow Branch Drive Orlando, FL 32828	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= G
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= G
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= G
St - A - 0125 - 58a-5.021(3) Fac - Fiscal - Surety Bonds S-S= D
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D
St - A - 0167 - 58a-5.025 Fac - Resident Contracts S-S= D

Specific Tag Findings:

0000-Initial Comments
A complaint investigation CCR #2014009069 was conducted at Avalon Assisted Living I on and Avalon's Assisted Living facility had deficiencies found at the time of the visit.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on observations, records review and interviews, the facility retained 1 of 3 sampled residents (#3) who had 2 pressure sores that did not show improvement within 30 days and became unstageable pressure sores and therefore exceeded assisted living residency criteria.

Findings:

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Partial thickness loss of dermis presenting as a shallow open with a red pink bed, without also present as an intact or open/ru -filled

Full thickness tissue loss. fat may be visible but bone, or muscle are *not* exposed. may be present but does not obscure the depth of tissue loss. include undermining and

Full thickness tissue loss with exposed bone, or muscle. or eschar may be present on some parts of the bed. *O ften* include undermining and

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Un-stageable: Full thickness tissue loss in which the base of the ... is covered by ... (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the ... bed." (www.woundconsultant.com).

Observations on ... at approximately 9:30 AM found resident #3 was in bed. He had dressings to both the heels/ankles. He had a hospital bed with overlay mattress.

Observations on ... at approximately 10 AM noted that an individual who had entered the facility signed a book. This person was contacted. She was a home care nurse and came to the facility to treat resident #3. She signed the visitors' in and out log. When the home care nurse was about the area on the resident's feet, she stated the right foot was intact with the dressing just for protection, and the left ankle had eschar and was unstageable. It was a pressure ... She uncovered the resident's large dressing to his left hip. His legs were contracted. She stated that on her visits, the resident was clean and dry and dressings in were in place.

Observations of the ... noted 2 open areas, packed with dressing. After the dressing was removed, 2 unstageable areas were noted. The base of the ... was covered by a thick layer of tissue. The nurse cleaned the ... using a cotton swab. As she cleaned the ..., it was noted that the ... was a left hip ... and ... connected with skin. She inserted a dressing on one side and it went thru the other side, where she took it out. After she cleaned the area, she applied Vanco/G... 2/2% and packed with it with Alginate and covered it with a double dressing. The prescription label was dated ... and indicated Vanco/G... 2/2% apply to affected area daily as directed. The left ankle had eschar (scab) which she painted with ... and covered with a dressing.

Record review for resident #3 revealed a health assessment report 1823 dated ... that listed diagnoses of ... accident ... high ..., and ... The resident needed assistance with bathing, dressing, ... toileting, ambulation, and transferring. The assessment indicated the resident had a pressure ... However, the stage was not indicated. The resident was admitted to the facility on ... Facility notes dated ... 5:30 PM indicated the resident went to the hospital for ... and low ... level. On ... at approximately 5 PM, he returned back to the facility from hospital. Health assessments forms 1823 dated ... and ... did not indicate the presence of a pressure ...

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Review of the home health care notes revealed the resident developed a red area to the left hip which did not show improvement within 30 days and became an unstageable [illegible] and [illegible] "A [illegible] is an empty space that can extend in any direction from the [illegible] (www.healthtap.com).

On [illegible], the resident had a [illegible] pressure [illegible] to the right [illegible] that measured 4 centimeters (cm.) by 4 cm. The left hip had [illegible] pressure [illegible]. The crease of the [illegible] area measured 2 cm. long.

On [illegible], the right [illegible] measured 6 cm. by 4.5 cm. by less than 0.1 cm.

On [illegible], the right [illegible] measured 7 cm. by 5 cm. by 0.

On [illegible], the right [illegible] fold was resolved on [illegible]. The right hip was red. The left hip had a cluster of [illegible], closed and measured 6 cm. by 7 cm. The only open area measured 2.8 cm. by 2.4 cm.

On [illegible], the left hip measured 1.6 cm. by 1.8 cm. with a dark red [illegible] bed. [illegible] #7 on the right hip measured 2 cm. by 2 cm. [illegible] #8 on the left hip measured 2 cm. by 0.8 cm. by less than 0.1 cm. The right [illegible] above the original [illegible] measured 8 cm. by 5.5 cm. by 1 cm.

On [illegible], the left hip measured "2.5 (cm.) x 6.6. (cm.) x (depth) unknown"

On [illegible], the right [illegible] had several small open areas. The [illegible] measured 0.3 cm. by 2.4 cm. by 0. The right lateral [illegible] measured 0.7 cm. by 2.6 cm. The right [illegible] measured 0.3 cm. by 1.5 cm. by 0 cm. The left hip [illegible] measured 2.5 cm. by 6.5 cm. with tan/brown eschar.

On [illegible], the left [illegible] measured 2.5 cm. by 6.5 cm. by unknown with tan brown eschar separating in the middle of the eschar. The right hip blanched.

On [illegible], the right [illegible], left [illegible] and [illegible] fold were resolved.

On [illegible], the left hip [illegible] area [illegible] was unable to measured because of [illegible] tissue undermining [illegible] bed with black/tan/brown thickness. The left hip [illegible] area [illegible] was unable to measured because of yellow [illegible]. The right [illegible] pressure [illegible] was a

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On , the left hip area measured 3 cm. by 2.5 cm. by 4 cm. with undermining which was unable to be measured. The left hip area measured 2 cm. by 2 cm. x 2.5 cm. and was unable to measured. The left measured 3 cm. by 1 cm.

On per staff statement, the left great toe had a hard scabbed area when the resident returned to the facility on .

On , the left hip was unable to be measured because of tissue, and the left hip was unable to be measured because of yellow .

On , the resident returned from the hospital with a .

On , the left hip had an opening smaller than the , with at 12 o'clock that measured 0.5 cm, at 9 o'clock that measured 0.6 cm., and at 6 o'clock that measured 1 cm.

On , the left hip bed was tan/green with undermining tissue damage. The left hip area had yellow and undermining tissue damage. The left great toe was not stageable. "Undermining is tissue destruction underlying intact skin along margins. (www.healthtap.com).

On , the left hip was unstageable. The left hip had with open connecting and wounds. The left heel was drying off gradually.

On , "Resuming care, returning from hospital." Left hip measured 2 cm. by 3 cm. by 1.3 cm. The left hip measured 1.5 cm. by 2 cm. by 0.6 cm. connecting to each other. The left heel had black eschar. The were both (redness).

On , the left hip had yellow/dark brown tissue. The left hip had yellow llow/green drainage into the .

On , the was packed with gauze and 2% and 2% powder was dusted into the .

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In an interview with the assistant administrator on at approximately 12 PM, he stated he did not know about the pressure sores being unstageable.

Class II

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, record review and interview, the facility failed to provide adequate supervision for a resident with who requires assistance with medication, failed to maintain a written record, updated as needed regarding any illnesses which resulted in medical attention and documentation of significant changes (improvement) that a resident could go from being a resident to a independent boarder, and failed to provide physician ordered medications for 1 of 6 residents (#2).

Findings:

Review of the facility Admission Discharge Log on at approximately 9:10 AM revealed that resident #2 was admitted on and discharged on It was noted on the log that the resident was discharged as an independent boarder per her request.

Resident #2's record review revealed a Resident Health Assessment for Assisted Living Facilities Form (1823) for Avalon Assisted Living II dated that listed diagnoses of "Attention to medications". The resident's or behavioral status read, "alert and oriented". service requirements read, "None." The 1823 stated the resident was independent with ambulation, bathing, dressing, eating, toileting and transferring. Page 4 of the 1823 read, "Does the individual need help taking his or her medications?" "No" was checked. There was a line through "Needs Assistance with Self-Administration of medications" and "Medication Administration". Additional comments read, the "resident may use a pill box filled by a professional nurse/Independent." The information on the 1823 was inconsistent regarding the resident's needs for medication.

Record Review of records obtained from the resident's physician dated indicated the following:
Phone Note:
Initial Intake Caller: Patient called at 1:23 PM
Type of Call: Low.
Concerns/Comments: Patient is low please call patient back. Phone number provided.
Response #1: She has not been seen in over a year therefore is she still paneled to us she

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needs appt for evaluation for any problems.
Response #2: Attempted to reach patient x 3 during the afternoon with no answer and unable to leave message as voicemail is not set up.

Phone call back from (staff #B), nurse from facility where patient is currently residing. Per staff #B patient has been doing well with no problems until the last couple of days her diastolic has been running low in the 40's. Patient's pulse is running around 66 to 78 with no other major symptoms. Discussed with PCP (primary care physician) and instructed to hold B/P meds if diastolic is low, continue monitoring and appointment was given for tomorrow at 9:30 AM for evaluation.

Patient came in today complaining of low . Patient was accompanied by a gentleman from the nursing home. They have a log of her and all of them are adequate. The lowest one is (Resident #2) once and she had no injuries but it was not because of low
Impression Recommendation:
#1 Accidental - comment only
#2 - Unchanged, No behavioral problems. Orders , Review of all medications.
#3 - unchanged, updated medication list includes 20 mg
#4 n-Essential Assessed As: unchanged.
Lower discussed with caretaker and monitor
The following medications were removed from the medication list:
40 mg tabs take one tablet by mouth every day
Her updated list for this problem includes:
20 mg tabs take one tablet by mouth every day
10 mg tabs take one tablet by mouth every day.

Patient Instructions:
1) Please schedule a follow up appointment in 3 months and bring all medications with you.
2) Be sure to have all labs work done one week before your next appointment as scheduled.

The Fax sent to The Agency for Health Care Administration (AHCA) office on from Family Physicians Group, the group treating the resident, was reviewed. Physician office visit notes go back to An office visit dated the last visit noted prior to survey on revealed the physician noted the current medications as: Oral 40 mg. (milligrams)/ml. (milliliter) 80 mg. by mouth daily, 25 mg. HCl), one tablet by mouth every day, 1000 mcg (micrograms)/ml. injectable solution every 2 weeks, 20 mg. one tablet by mouth every day,

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10 mg. one tablet by mouth every day, 10 mg. one tablet by mouth every day, and 10 mg. (Amiodipine one tablet by mouth every day.

During an interview on with staff #B, she went to the garage and brought out a box of medications and stated it belonged to resident #2. In the box were the five following medications: 20 mg. tablets - filled with 23 tablets left, 25 mg. tablets -filled 20 mg. capsules - filled with 30 capsules left, Amiodipine 10 mg. - filled with 15 tablets left, Loratab 10 mg. - filled with 23 tablets left. Oral 40 mg./ml. suspension, 1000 mcg./ml. injection solution, and 10 mg. tabs were not available at the facility.

Nothing in physician's records reflected the resident's ability to thrive as an independent resident. Nothing in the facility's records, prior to the facility's decision to discharge the resident as "independent", reflected any improvement in the resident's capacity.

The resident's documented status prior to being discharged as an "independent " boarder is inconsistent with the assertion the resident had the capacity to determine the resident could live independently. Any such change in status would constitute a significant change in condition requiring the facility to contact the resident's health care provider and responsible party. The facility did not make any such contacts and as demonstrated by the resident's physician notes of a physician's visit on 2014, took the resident to the health care provider where the assistant administrator represented that the resident resided in an assisted living facility, received assistance with medications, laundry services, and shopping.

In an interview conducted with the assistant administrator, he stated there were no records for the resident regarding her or any medical care because she is an independent boarder. The assistant administrator did not provide any records from the time resident #2 was a resident of the facility

The resident was not taken back to the physician in three months as the physician had ordered. There was no Medication Observations Records (MORs) to review to determine if the resident was getting the medications that were ordered by the physician. The resident has a history of and with dating back to

Class II

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0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on interview and record review, the facility failed to ensure residents manage their financial affairs unless the resident or, if applicable, the residents' representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds for 1 of 6 residents (#2).

Findings:

Interview conducted with resident #2 on at approximately 12:30 PM who was asked about her medications. She stated she does not take medications. Resident #2 was unable to give any information regarding her medications or medical needs. The resident was not able to give information regarding any rental agreement with the facility such as how much her rent is or what her financial assets are or who is managing them. She then presented a Raggedy Ann and Andy Doll she kept wrapped in a pillow case in her dresser drawer.

In an interview conducted on at 11:15 AM, resident #2's family member stated resident #2 is a resident of the facility and not a boarder. The family member said "She is doing fine there. They give her medications; sometimes she refuses. She lives at the Avalon Assisted Living Facility 24/7, they watch her all the time. She gets an annuity from an investment she made to hospice plus social security." The family member stated she is no longer a representative payee and that resident #2 lived with the family member for four years. The family member stated she had power of attorney but "the state took her from me." One night she started saying crazy things, accusing the family and the family member's grandson of taking her money. Resident #2 has a history of abusing medications, especially The of caused and half of her stomach had to be removed. The family member stated that she could not keep the resident in the house because she started "wandering in all around the neighborhood. Someone called the Department of Children and Families (DCF) and this is where we are now with her living in the ALF."

Review of records obtained from the Social Security Administration on revealed an application submitted by the administrator of the facility dated requesting to be the payee for resident #2. The administrator provided her date of birth, social security number and a copy of her driver's license. The administrator also asserted to the Social Security Administration that she was the resident's case worker, that the resident needed a payee for benefits as the resident has a mental and that the resident resides in a board and care home. A second document dated stated the administrator was chosen to be the representative payee for resident #2 and she would receive $983.00 on 2013 and on or about the third of each month.

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Interview with the assistant administrator revealed that the facility was not the representative payee of any of the residents in the facility. The assistant administrator was specifically asked was the administrator/owner the representative payee and he responded "no". However, based on documentation received from the social security administration, the administrator made an application to be made as representative payee for resident #2 on [redacted] and this was approved on [redacted].

Class II

0077-Staffing Standards - Administrators 58A-5.019(1) FAC

Based on record review, the administrator 1. falsified the readmission of a resident and discharged a resident of the assisted living facility who had a history of [redacted] as an independent boarder who is not receiving services for 1 of 6 residents (#2). 2. retained 1 of 6 sampled residents with 2 pressure sores that did not show improvement within 30 days and became unstageable pressure sores and therefore exceeded assisted living residency criteria (#3). 3. failed to provide adequate supervision to 1 of 6 sampled residents with [redacted] who requires assistance with medications (#2). 4. failed to maintain a written record, updated as needed regarding any illness which resulted in medical attention. 5. failed to provide physician ordered medications for 1 of 6 residents (#2). 6. failed to provide safe keeping for funds for 1 of 6 residents (#2). 7. acted as a representative payee for 1 of 6 residents #2). 7. failed to maintain a surety bond twice the monthly income of a resident and served as the representative payee for 1 of 6 residents (#2). 8. failed to provide a quarterly statement detailing the income and expense records for 1 of 6 residents and acted as a representative payee for 1 of 6 residents (#2). 9. failed to ensure demographic information was available for 1 of 6 sampled residents (#2). 10. failed to maintain an up to date admission discharge log for 1 of 6 residents (#2). 11. failed to execute a contract with 1 of 2 residents (#2).

Findings:

1. Resident #2's record review revealed a Resident Health Assessment for Assisted Living Facilities Form (1823) for Avalon Assisted Living II dated [redacted] that read "Attention to medications". There was no medical diagnosis listed. The resident's [redacted] or behavioral status read, "alert and oriented". [redacted] service requirements read, "None". The 1823 stated the resident was independent with ambulation, bathing, dressing, eating, [redacted] toileting and transferring. Page 4 of the 1823 read, "Does the individual need help taking his or her medications?" "No" was checked. There was a line through the "Needs Assistance with Self-Administration of medications" and "Medication Administration".

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Additional comments read, the "resident may use a pill box filled by a professional nurse/Independent." The information on the 1823 was inconsistent regarding the resident's needs for medication.

Review of a fax received on [redacted] at 6:05 PM from the assistant administrator included Facility Payment Plan for resident #2 indicating a small semi-private [redacted] the amount per month listed and signed by resident #2 and the facility administrator, dated [redacted]. Also included in the fax was a Facility Admission Contract dated [redacted] for resident #2. Fax cover letter read "contract for [redacted] when resident #2 was a resident. The assistant administrator wrote "per admission and discharge log (resident #2) requested to be an independent boarder."

In an interview on [redacted] at approximately 9:30 AM, staff #B, the person who went to the garage to get a plastic box with medications labeled for resident #2, stated she keeps the medications locked and brings them to the resident when she (the resident) is supposed to take them. Staff #B stated she watches the resident take the medications at the allotted time to make sure she takes them right. Staff #B stated there is no Medication Observation Record (MOR) for resident #2.

The assistant administrator stated on [redacted] at approximately 10:15 AM that resident #2 was admitted to Avalon Assisted Living Facility II on [redacted] from her sister's home. She was removed from the sister's home by Adult Protective Services due to alleged [redacted] He said resident #2 requested to be an independent boarder. Resident #2 was discharged from Avalon Assisted Living II on [redacted] and moved to Avalon Assisted Living I as an independent boarder. Resident #2 did not have a rental agreement with the facility. He stated the resident was an independent/boarder with no rental agreement, was not a resident, and takes her own medications.

Review of physician's note dated [redacted] under Instrumental Activities of Daily Living Transportation - dependent, Meal/Food Preparation- dependent, Shopping Errands -dependent, Housekeeping/Chores-dependent, Money management/Finances- independent, Medication Management- assisted, Ability to use Telephone- dependent, Laundry- dependent. The note read in part, "Patient lives in an assisted living facility where they provide transportation to appointments or labs. Her medication per the supervisor (assistant administrator) is locked in a closet and given to her daily. Housekeeping, laundry is done by the facility so is the shopping. Patient was asked who manages her money and she stated she handle her own finances. When asked how she spends her money she told me that was not my business....Overall Assessment: partially dependent."

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On , the assistant administrator stated under oath at a deposition in an action regarding the facility that resident #2 is now only a renter living in the Assisted Living Facility so she is no longer receiving the protection afforded a resident to include the requirements that regulate help with assistance with self-administration of medications.

In an interview on at approximately 12:30 PM, resident #2 was asked about her medications and stated she does not take medications. Resident #2 was unable to give any information regarding her medications or medical needs, any rental agreement with facility, how much her rent is or what her financial assets are and who is managing them. During the interview, she presented a Raggedy Ann and Andy Doll she kept wrapped in a pillow case in her dresser drawer.

2. Observations on at approximately 9:30 AM found resident #3 in a hospital bed with overlay mattress that was set at 5. He had dressings to both the heels/ankles. At approximately 10 AM, a home care nurse arrived at the facility and said she was there to treat resident #3. When asked about the area on the resident's feet, she stated the right foot was intact and the dressing was placed there for protection. Observation of the resident's left ankle found it with eschar and unstageable pressure . The home care nurse then uncovered the resident's left hip dressing. His legs were contracted. The home care nurse stated that on her visits, the resident was clean and dry and dressings were in place. Observations of the noted 2 open areas, packed with dressing. After the dressing was removed, 2 unstageable areas were seen. The base of the was covered by a thick layer of tissue. The nurse cleaned the using a cotton swab. As she cleaned it, it was noted that the was at the left hip and connected with skin, She inserted a dressing one side and it went through to the other side, where she took it out. After she cleaned the area, she applied Vanco/G 2/2%, packed with it with Alginate, and covered it with a double dressing. The prescription label was dated and indicated Vanco/Gent 2/2% apply to affected area daily as directed. Observations of the left ankle found eschar on it and she painted it with and covered it with a dressing.

Resident #3's record review revealed a health assessment report 1823 dated that listed diagnoses of , , , accident high , , and . The health assessment indicated the resident needed assistance with bathing, dressing, toileting, ambulation, and transferring. The health assessment indicated the resident had a pressure but the stage was not listed. The resident was admitted to the

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facility on .

: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Partial thickness loss of dermis presenting as a shallow open with a red pink bed, without also present as an intact or open/r -filled

: Full thickness tissue loss. fat may be visible but bone, or muscle are *not* exposed. may be present but does not obscure the depth of tissue loss. include undermining and

: Full thickness tissue loss with exposed bone, or muscle. or eschar may be present on some parts of the bed. Often include undermining and Un-stageable: Full thickness tissue loss in which the base of the is covered by (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the bed." (www.woundconsultant.com).

Review of the home health care notes on revealed the resident developed a red area to the left hip which did not show improvement within 30 days and became an unstageable and pressure Condition of the resident's skin is as follows:

On the resident had a pressure to the right that measured 4 centimeters (cm.) by 4 cm. The left hip had pressure The crease of the area measured 2 cm. long.

On the right measured 6 cm. by 4.5 cm. by less than 0.1 cm.

On , the right measured 7 cm. by 5 cm. by 0.

On the right fold was resolved on The right hip was red. The left hip had a cluster of , closed and measured 6 cm. by 7 cm. The only open area measured 2.8 cm. by 2.4 cm.

On the left hip measured 1.6 cm. by 1.8 cm. with a dark red bed. #7 on the right hip measured 2 cm. by 2 cm. #8 on the left hip measured 2 cm. by 0.8 cm. by less than 0.1 cm. The right above the original measured 8 cm. by 5.5 cm. by 1 cm.

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Avalon's Assisted Living	1250 Willow Branch Drive Orlando, FL 32828	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

On , the left hip measured "2.5 (cm.) x 6.6. (cm.) x (depth) unknown"

On , the right had several small open areas. The measured 0.3 cm. by 2.4 cm. by 0. The right lateral measured 0.7 cm. by 2.6 cm. The right measured 0.3 cm. by 1.5 cm. by 0 cm. The left hip measured 2.5 cm. by 6.5 cm. with tan/brown eschar.

On , the left measured 2.5 cm. by 6.5 cm. by unknown with tan brown eschar separating in the middle of the eschar. The right hip blanched.

On , the right , left and fold were resolved.

On , the left hip area was unable to measured because of tissue undermining bed with black/tan/brown thickness. The left hip area was unable to measured because of yellow . The right pressure was a

On , the left hip area measured 3 cm. by 2.5 cm. by 4 cm. with undermining which was unable to be measured. The left hip area measured 2 cm. by 2 cm. x 2.5 cm. and was unable to measured. The left measured 3 cm. by 1 cm.

On per staff statement, the left great toe had a hard scabbed area when the resident returned to the facility on .

On the left hip was unable to be measured because of tissue, and the left hip was unable to be measured because of yellow .

On , the resident returned from the hospital with a .

On , the left hip had an opening smaller than the , with at 12 o'clock that measured 0.5 cm, at 9 o'clock that measured 0.6 cm., and at 6 o'clock that measured 1 cm.

On , the left hip bed was tan/green with undermining tissue damage. The left hip area had yellow and undermining tissue damage. The left great toe was not stageable. "Undermining is tissue destruction underlying intact skin along margins. (www.healthtap.com).

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On the left hip was unstageable. The left hip had with open connecting and wounds. The left heel was drying off gradually.

On , "Resuming care, returning from hospital." Left hip measured 2 cm. by 3 cm. by 1.3 cm. The left hip measured 1.5 cm. by 2 cm. by 0.6 cm. connecting to each other. The left heel had black eschar. The were both (redness).

On , the left hip had yellow/dark brown tissue. The left hip had yellow llow/green drainage into the

On , the was packed with gauze and 2% and 2% powder was dusted into the

In an interview with the assistant administrator on at approximately 12 PM, he stated he did not know about the pressure sores being unstageable.

3. Review of the facility's Admission Discharge Log revealed that resident #2 was admitted on and discharged on It noted that resident was discharged as independent boarder per her request.

Resident #2's record review revealed a Resident Health Assessment for Assisted Living Facilities Form (1823) for Avalon Assisted Living II dated that read, "Attention to medications". The resident's or behavioral status read, "alert and oriented", service requirements read, "None." The 1823 indicated that the resident was independent with ambulation, bathing, dressing, eating, toileting and transferring. Page 4 of the 1823 read, "Does the individual need help taking his or her medications?" "No" was checked. There was a line through the "Needs Assistance with Self-Administration of medications" and "Medication Administration". Additional comments read, the "resident may use a pill box filled by a professional nurse/Independent." The information on the 1823 was inconsistent regarding the resident's needs for medication.

4. Resident #2's record review of Physician record dated Note indicated:
Phone Note:
Initial Intake Caller: Patient called at 1:23 PM
Type of Call: Low.
Concerns/Comments: Patient is low please call patient back. Phone number provided.

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Response #1: She has not been seen in over a year therefore is she is still paneled to us she needs apt for evaluation for any problems.
Response #2: Attempted to reach patient x 3 during the afternoon with no answer and unable to leave message as voicemail is not set up.

Phone call back from (staff #B), nurse from facility where patient is currently residing. Per (staff #B) patient has been doing well with no problems until the last couple of days her diastolic has been running low in the 40's. Patient's pulse is running around 66 to 78 with no other major symptoms. Discussed with PCP (primary care physician) and instructed to hold B/P meds if diastolic is low, continue monitoring and appointment was given for tomorrow at 9:30 AM for evaluation.

Patient came in today complaining of low Patient was accompanied by a gentleman from the nursing home. (He said) they have a log of her B's and all of them are adequate. The lowest one is (Resident #2) once and she had no injuries but it was not because of low
Impression Recommendation:
#1 Accidental comment only
#2 - Unchanged, No behavioral problems. Orders Review of all medications.
#3 - unchanged, updated medication list includes 20 mg
#4 n-Essential Assessed As: unchanged.
Lower discussed with caretaker and monitor
The following medications were removed from the medication list:
40 mg. tabs take one tablet by mouth every day
Her updated list for this problem includes:
20 mg tabs take one tablet by mouth every day
10 mg tabs take one tablet by mouth every day.
Patient Instructions: 1) Please schedule a follow up appointment in 3 months and bring all medications with you. 2) Be sure to have all labs work done one week before your next appointment as scheduled.

5. The Fax sent to The Agency for Health Care Administration (AHCA) office on from Family Physicians Group, the group treating the resident, was reviewed. Physician office visit notes go back to An office visit dated , the last visit noted prior to survey on revealed the physician noted the current medications as: Oral 40 mg. (milligrams)/ml. (milliliter) 80 mg. by mouth daily, 25 mg. HCl), one tablet by mouth every day, 1000 mcg (microgr injectable solution every 2 weeks, 20 mg. one tablet by mouth every day,

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10 mg. one tablet by mouth every day, 10 mg. one tablet by mouth every day, and 10 mg. (Amiodipine one tablet by mouth every day. Oral 40 mg. /ml sups, 1000 mcg./ml. injectable solution and 10 mg. tablets were not available at the facility.

In an interview conducted with the assistant administrator, he stated there are no records for the resident regarding her or any medical care as she is an independent boarder. He was unable to produce any records from the time resident #2 was a resident of the facility from .

6. In an interview with resident #2 on at approximately 12:30 PM, when asked about her medications, she stated she does not take medications. Resident #2 was unable to give any information regarding her medications or medical needs, any rental agreement with facility, how much her rent is or what her financial assets are or who is managing them. She presented a Raggedy Ann and Andy Doll she kept wrapped in a pillow case in her dresser drawer.

Social Security Administration confirmed that the facility's administrator is the representative payee for resident #2's Social Security money.

In an interview on at approximately 2 PM, the assistant administrator stated that the facility is not the representative payee or attorney in fact for any residents of the facility including resident #2, who he considers an independent boarder.

7. In an interview conducted on at approximately 11:45 AM, the assistant administrator stated he did not have access to the facility financial information. He would have to call the accountant to get the information regarding monthly statements and surety bond.

Interview conducted on at approximately 12:30 PM, resident #2 stated the administrator is not her representative payee. The resident stated that her money is in an account at the bank and she is in charge of it. She could not give the name of the bank or type of account.

A fax received on from the assistant administrator read, "Surety Bond - No rep-payee or attorney- in-fact relationship exists for any residents. Not required." Funds - Resident funds are not handled by facility or facility staff....Monthly/Quarterly statements for any residents - none given".

8. In an interview on TIME with assistant administrator who stated he did not have

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access to the facility financial information. He would have to call the accountant to get the information regarding any financial statements. He stated that he has no record available for resident #2 because resident is an independent boarder and the facility or facility staff do not assist her with finances.

Fax received on ..... from the assistant administrator read, "Surety Bond-No rep-payee or attorney- in-fact relationship exists for any residents. Not required". Monthly/Quarterly statements for any resident, none given".

9. Review of the facility's admission discharge log revealed resident #2 was admitted as a resident on ..... and discharged on ..... It was noted that the resident was discharged as an independent boarder at her own request.

Resident record review revealed a Resident Health Assessment for Assisted Living Facilities Form (1823) for Avalon Assisted Living II dated ..... that read, "Attention to medications". The resident's ..... or behavioral status stated; "alert and oriented". ..... service requirements stated, "None". The 1823 stated the resident was independent with ambulation, bathing, dressing, eating, ... toileting and transferring. Page 4 of the 1823 read, "Does the individual need help taking his or her medications?" "No" was checked. There was a line through the "Needs Assistance with Self-Administration of medications" and "Medication Administration". Additional comments read, the "resident may use a pill box filled by a professional nurse/Independent." The information on the 1823 was inconsistent regarding the resident's needs for medication.

In an interview on ..... at approximately 2:30 PM, the assistant administrator stated there was no demographic page for resident #2. There was no file for resident #2 because he considers her an independent boarder. He was unable to produce a record from the time the resident was admitted to the facility as a resident from .....

Review of fax received on ..... at 6:05 PM from Assistant Administrator included Facility Payment Plan for resident #2 indicating semi Private ..... (small), $1,850.00/ month. Signed by resident #2 and the facility administrator, dated ..... Also included in the fax is a Facility Admission Contract dated ..... for resident #2. Fax cover letter stated " contract for when, resident #2 was a resident ..... Assistant Administrator wrote "per admission and discharge log resident #2 requested to be an independent boarder".

Facility records for resident #2 did not reflect any improvement in the resident's ..... status prior to facility's decision to discharge the resident as "independent." The resident was in need of assistance with medications and required the demographic

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information to be completed.

10. Review conducted of the facility's admission discharge log revealed resident #2 was admitted as a resident on and discharged on It was noted that resident was discharged as an independent boarder at her own request.

11. In an interview on at approximately 12:30 PM, resident #2 was not able to state what she was paying for rent at the facility. She only stated she was kidnapped and brought to the facility.

In an interview on at approximately 1 PM, the assistant administrator stated that there was no current lease or contract with resident #2 as she is considered an independent boarder.

Review of a fax received on at 6:05 PM from the assistant administrator included the Facility Payment Plan for resident #2 indicating a small semi-private cost of $1,850.00 per month. This was signed by resident #2 and the facility administrator dated Also included in the fax is a Facility Admission Contract dated for resident #2. Fax cover letter read, "contract for when (resident #2) was a resident The assistant administrator wrote "per admission and discharge log (resident #2) requested to be an independent boarder".

Class II

0125-Fiscal - Surety Bonds 58A-5.021(3) FAC
Based on interview and record review the administrator failed to maintain a surety bond twice the monthly income of a resident administrator serves as the representative payee for 1 of 6 residents sampled resident (#2)

Findings:

Review of Records obtained from the Social Security Administration on revealed an application submitted by Administrator dated requesting to be the payee for resident #2. Administrator provided her date of birth, social security number and a copy of her driver ' s license. A second document dated stated that Administrator was chosen to be the representative payee for Resident #2 and she would receive $983.00 on 2013 and on or about the third of each month.

In an interview conducted on with the assistant administrator who stated he did not

have access to the facility financial information. He would have to call the accountant to get the information regarding monthly statements and surety bond.

Interview conducted with resident #2 on [redacted] at approximately 12:30 PM who stated the administrator is not her representative payee. Resident stated that her money is in an account at the bank and she is in charge of it. She could not give the name of the bank or type of account.

Fax received on [redacted] from assistant administrator stated "Surety Bond- No rep-payee or attorney -in-fact relationship exists for any residents. Not required". Funds- Resident funds are not handled by facility or facility staff. "Monthly/Quarterly statements for any residents none given".

Class III

0160-Records - Facility 58A-5.024(1) FAC
Based on observation, record review and interview the facility failed to ensure demographic information was available for 1 of 6 sampled residents (#2).The facility failed to maintain an up to date admission discharge log for 1 of 6 residents (#2).

Findings:
Review conducted on [redacted] at approximately 9:20 AM of the facility admission discharge log revealed resident #2 admitted as a resident on [redacted] and discharged on [redacted] It was noted that resident was discharged as an independent boarder at her own request.

Resident record review conducted on [redacted] for resident #2 revealed a Resident Health Assessment for Assisted Living Facilities Form (1823) for Avalon Assisted Living II dated [redacted] that stated diagnoses of "Attention to medications". The resident's [redacted] or behavioral status was documented as "alert and oriented ". [redacted] service requirements stated, "None." The 1823 stated the resident was independent with ambulation, bathing, dressing, eating, [redacted] toileting and transferring. Page 4 of the 1823 stated, "Does the individual need help taking his or her medications?" "No" was checked. There was a line through the "Needs Assistance with Self-Administration of medications" and " Medication Administration". Additional comments stated, the "resident may use a pill box filled by a professional nurse/Independent." The information on the 1823 was inconsistent regarding the resident's needs for medication.

Interview conducted with Assistant Administrator on [redacted] at approximately 2:30PM who stated there is no demographic page for resident #2. There is no file for resident #2 because

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he considers her an independent boarder. He is unable to produce a record from the time resident was admitted to the facility as a resident from .

Review of fax received on at 6:05PM from Assistant Administrator included Facility Payment Plan for resident #2 indicating semi Private (small), $1,850.00/ month. Plan was signed by resident #3 and the facility administrator, dated . Also included in the fax is a Facility Admission Contract dated for resident #2. Fax cover letter stated " contract for when, resident #2 was a resident Assistant Administrator wrote "per admission and discharge log resident #2 requested to be an independent boarder".

The resident was in need of assistance with medications and required the demographic information needed to be completed.
Class III

0162-Records - Resident 58A-5.024(3) FAC
Based on interview and record review the administrator failed to provide a quarterly statement detailing the income and expense records for 1 of 6 resident ' s (#2) that the administrator acts as representative payee for.

Findings:

Interview conducted on with assistant administrator who stated he did not have access to the facility financial information. He would have to call the accountant to get the information regarding any financial statements. Assistant administrator stated further that he has no record available for resident #2 because resident is an independent boarder and the facility or facility staff do not assist her with finances.

Fax received on from the assistant administrator who stated "Surety Bond-No rep-payee or attorney- in-fact relationship exists for any residents. Not required". Monthly/Quarterly statements for any resident, none given".

Review of Records obtained from the Social Security Administration on revealed an application submitted by Administrator dated requesting to be the payee for resident #2. Administrator provided her date of birth, social security number and a copy of her driver's license. A second document dated stated that Administrator was chosen to be the representative payee for Resident #2 and she would receive $983.00 on 2013 and on or about the third of each month.

Class III

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0167-Resident Contracts 58A-5.025 FAC
Based on record review and interview the facility failed to execute a contract with 1 of 2 Residents reviewed #2.

Findings:

Interview conducted on [redacted] at approximately 12:30PM with resident #2 who was not able to state what she was paying for rent at the facility. She only stated she was kidnapped and brought to the facility.

Interview conducted on [redacted] at approximately 1:00PM with Assistant Administrator who stated that there is no current lease or contract with resident #2 as she is considered an independent boarder.

Review of fax received on [redacted] at 6:05PM from Assistant Administrator included Facility Payment Plan for resident #2 indicating semi Private [redacted] (small), $1,850.00/ month. The plan was signed by resident #3 and the facility administrator, dated [redacted] Also included in the fax is a Facility Admission Contract dated [redacted] for resident #2. Fax cover letter stated " contract for when, resident #2 was a resident [redacted] Assistant Administrator wrote "per admission and discharge log Resident #2 requested to be an independent boarder".

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Avalon's Assisted Living
1250 Willow Branch Drive
Orlando, FL 32828

RE: CCR #2014009069

Dear Administrator:

This letter reports the findings of a state licensure 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 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

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

20. 2014

Avalon's Assisted Living
1250 Willow Branch Drive
Orlando, FL 32828
Chiqquittia Carter-Walker, Administrator

Dear Carter-Walker:

This letter reports the findings of a Complaint (CCR#2014009069) inspection survey conducted on , by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

1) A0010 - Admissions - Continued Residency Class II
Your Assisted Living Facility failed to ensure that residents admitted to your facility continued to be appropriated for continued residency when a resident developed unstageable pressure sores was allowed to remain in the facility.

2) A0025 - Resident Care - Supervision Class II
The assisted living facility failed to provide adequate supervision to residents who were at risk and needed supervision and the facility made the resident an independent border. The resident has a history of dating back to 2009 and needs supervision with medications and daily oversight. The facility need to make sure that residents are appropriately assessed for level of care.

3) A0030 - Resident Care - Rights & Facility Procedures Class II
The Assisted Living facility need to ensure residents manage their financial affairs unless the resident or, if applicable the residents representative, designee, surrogate, guardian, or attorney in-fact authorizes the administrator of the facility to provide safekeeping for funds. The facility should make every effort to make sure their are no power attorney's or family members that can be charge of the residents finances before making themselves payee.

4) A0077 - Staffing Standards - Administrators Class II
The Assisted Living facility's Administrator failed to provide adequate oversight of the facility and the facility staff by falsifying the readmission of a resident. The administrator discharged a resident of the assisted living facility who had a history of

as an independent boarder who is not receiving services. 2. Retained a resident who had two pressures sores that did not show improvement within 30 days and became unstagable pressure sores, therefore exceeded assisted living residency criteria. 3. failed to provide adequate supervision. 4. Failed to maintain a written record, updated as needed regarding any illness which resulted in medical attention. 5. Failed to provide physician ordered medications. 6. The administrator failed to provide safekeeping of residents funds. 7. The administrator acts as representative payee . 8. Administrator failed to maintain a surety bond twice the monthly income of a resident. 9. The administrator failed to provide a quarterly statement detailing the income and expense records. 10. The administrator failed to maintain an up to date admission discharge log. 11. The administrator failed to ensure demographic information was available. 12. Thai administrator failed to execute a contract.

Your facility must comply with the following:

1) Your facility must re-assess and evaluate residents for the appropriateness of continued placement in your assisted living facility. All disciplines should be present when the continued residency of a resident is discussed. This will allow all who work with the resident the opportunity to give pertinent information about the resident. Also, complete updated health assessments to document continued appropriateness for residency. This must be completed with **5 calendar days** from the date of this letter.

2) The Assisted Living Facility should be in constant communication with all outside agency's that enter the facility to provide care to the residents of the Assisted Living facility. This communication between the outside agency and the facility should be documented and available for review by the agency upon request. The documentation may be through the use of a log and/or notes. This will enable the facility have documentation of communication with outside agencies and any concerns or issues the facility will need to convey to the outside agencies. This must be completed with **5 calendar days** from the date of this letter.

3) There should be a care plan put in place to address issues or concerns that may arise when the outside agencies not at the facility and may not be there for a couple of days. The care plan should be documented and available for review by the agency upon request. The facility has the ultimate responsibility to ensure their residents are receiving adequate care. This must be completed with **5 calendar days** from the date of this letter.

4) The facility need to retrain all staff on the appropriateness of residents in an assisted living facility. Changes in resident's health should be reported immediately to the administrator so that a decision can be made about the residents continued appositeness. This must be completed with **5 calendar days** from the date of this letter.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call ..... Lorraine Henry, ALF Supervisor Orlando Office, at (407) 420-2534.

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

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone (407) 420-2502; Fax (407) 245-0998

Avalon's Assisted Living

Sincerely,

ALF Supervisor

D7JR

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