STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910737	05/20/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
AVALON PARK RETIREMENT RESIDENCE, INC	604 NORTH 62ND AVENUE HOLLYWOOD, FL 33024	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced Extended Congregate Care monitoring survey was conducted on at Avalon Park Retirement Residence LLC. The facility had deficiencies found at the time of the visit.

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

Based on observations, and interviews, the facility failed to treat 1 out of 2 sampled residents (Resident # 1) with dignity; by allowing her the freedom to self-feed and failed to honor 1 out of 2 sampled resident ' s right for privacy (Resident # 2).

The findings include:

a) Upon entering the facility on at 8:25 AM, it was observed that an unidentified employee named (Employee A) was feeding Resident #1 her breakfast. While observing the feeding process, this writer noted that Employee #1(unaware that she was being observed) was not only feeding the resident at a fast pace but she was standing next to the resident (over the resident ' s left side) and feeding her. Additionally, the resident was observed being displeased for the way she was being fed looking at her facial expression. When Employee (A) made an attempt to put another spoon of food in the resident ' s mouth, although the resident ' s mouth had food in it the resident frowned at her and tried to speak with her mouth full in rejection. However, it was noted that the aide disregarded the resident ' s rejection and still proceeded to put the food in the resident ' s mouth. The resident was observed turning her face away from the spoon and the employee at that time.

Upon approaching Employee (A) and questioning her about her demeanor and the way she was feeding the resident, she confirmed that Resident #1 was able to feed herself, but specified that Resident #1 is not always able to do so (she said that she was feeding the resident because sometimes she does not want to eat). Employee (A) also reported that she has been working at the facility for only a month. Hurriedly, Employee (A) asked if she could go to complete her assignment, to which this writer agreed; she left the remainder of the resident ' s food and went to the kitchen.
Soon after Employee (A) returned and brought back with her a cup of drink which she handed to the resident and the resident was observed feeding herself without any assistance.

A subsequent attempt to talk with Resident #1, thereafter revealed that she lacked abilities. She looked at the interviewer and did not answer any of the questions she was asked. Review of the Resident's Health Assessment form (AHCA form 1823) revealed that she was admitted to this facility on The record also revealed that she suffers from and ; she is alert and oriented x2 and is independent to feed herself.

During an interview with the Nurse at 10:45 AM, he reported that he has not noted any declines in Resident #1 ' s or physical abilities. He indicated that the resident ' s level has changed from the time she was admitted to the facility till now. She is not able to be interviewed. Review of Resident #1 ' s weight records for the

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past 3 months revealed no significant changes; on she weighted 124 lbs and on 2015 she weighted 125 lbs.

During a follow-up interview on 12:35 PM, with the Administrator and her assistant, they confirmed that Resident #1 is able to feed herself. However, she experiences periods of during which time she does not know what to do with her food. But, once she is fed one spoon, she is able to continue by herself.

b) At about 10:12 AM on the same day, during an interview with Resident #2 in the resident ' s , the interview was abruptly interrupted by the sudden entrance of Employee B in the knocking. Once, in the without saying a word to either the resident or the interviewer (the Surveyor), Employee B was observed making an attempt to remove a medication. At that moment, Employee B was stopped and asked to replace the medication on the table. When asked why she was removing the medication, Employee B stated that she was going to dispose of it (thinking that the capsule was empty). However, the resident had not even taken the medication as of yet. While talking to the employee, she exited the she was told that we (the resident and this writer) were in the middle of an interview.

During a follow-up interview with Employee B, when she had returned to the remove the medication . When asked if she is the one who gave the medication to the resident she denied it and stated that " I am not a nurse, the nurse give medications ". However, during an interview with the Nurse at 10:20 AM, he reported that he had given the medication to the aide to give to the resident with her breakfast. Yet, the resident did not take the medication.

During the exit meeting, the Administrator and her assistant revealed that the Resident #2 was admitted to the facility the night before the survey. However, they indicated their disappointment of the staff behaviors.

Class III

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

Based on observation, interview and record review, the facility failed to ensure that 4 out of 4 sampled Medication observation records (MOR) reviewed were updated timely to maintain the accuracy of the record.
The findings include:
On at 8:57 AM, Employee B a licensed practical nurse responsible for medication administration and assisting the residents with medications self-administration was observed signing the residents ' medication observation records (MORs) without any resident being present. Subsequent to that observation, an interview was immediately conducted with Employee B who acknowledged that he had given all the residents their medications earlier that morning and that he did not have time to sign the MOR.
Upon reviewing the MOR at around 9:00 AM, it was noted that 4 of the MORs were not yet signed and Employee B was asked to make a photocopy of the evidence. However, he signed three of them before making the photo copies. During a follow-up interview, thereafter with Employee B, he acknowledged the findings and apologized for

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his actions.
During the exit meeting with the Administrator, he indicated that Employee B had been through many surveys before and that he was surprised that this incident had occurred.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Avalon Park Retirement Residence, Inc
604 North 62nd Avenue
Hollywood, FL 33024

RE: Extended Congregate Care

Dear Administrator:

This letter reports the findings of a State Licensure Survey that was conducted on , 2015 by representative from this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381 - 5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/jw
Enclosure

XG90

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