STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966313	07/23/2015
NAME OF PROVIDER OR SUPPLIER **PARADISE VILLA RETIREMENT HOME AT PEMBROKE PINE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1145 NW 92ND AVENUE PEMBROKE PINES, FL 33024**	

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

0000 Initial Comments

An unannounced Complaint Survey, CCR#2015004155, was conducted at Paradise Villa Retirement Home at Pembroke Pines on 07/23/15. The facility had deficiencies at the time of the visit.

0008 Admissions - Health Assessment

Based on interview and record review the facility failed to obtain updated 1823 Health Assessments form for changes in status for 2 of 3 residents reviewed (Resident #1 & Resident #3), as evidenced by no documentation the residents were admitted to hospice services and no documentation of wounds for Resident #1 and Resident #3.

The Findings Include:

1) Resident #1 was admitted to the facility on / with diagnoses to include , agitation and history of . Review of the resident's record revealed he sustained a on / / resulting in a hematoma to his forehead. On / / he had a choking episode and was admitted to the hospital with a readmission to the facility on . Review of the Observation Notes dated documents 'Resident returned to the facility AAO (awake, alert, oriented) x 3. Skin with multiple . He returned on hospice care.'

On at 10:40 AM, an interview was conducted with the Licensed Practical Nurse (LPN) Administrator who stated Resident #1 always had due to fragile skin. The LPN Administrator confirmed that Resident #1 was readmitted under hospice services.

Review of the latest 1823 Health Assessment dated / available in the resident's record, documented a diagnosis of , unsteady gait and episodes of . Further review of the 1823 reveled no documentation the resident was on hospice services, no evidence the resident had multiple and no evidence the resident, with a history of , required precautions. Additionally, the resident had a documented choking incident on / which required him to be transferred to the hospital for evaluation. There is no documentation on the 1823 for , precautions or change in consistency of diet.

2) Resident #3 was admitted to the facility on with diagnoses to include , and decline in function. Review of the resident's record revealed a physician order dated / for a referral to hospice, non-healing . Further review of the resident's record revealed the last 1823 Health Assessment is dated / . There was no evidence of documentation the resident was admitted to hospice services and had a non-healing .

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On 07/23/15 at 1:10 PM an interview was conducted with the LP Administrator who confirmed the 1823 Health Assessments were not updated for Residents #1 and #3 to reflect admission to hospice and the presence of wounds.

Class III

0025 Resident Care - Supervision

Based on interview and record review the facility failed to ensure resident records accurately reflected their condition for 2 of 3 residents sustaining , (Resident #1 and Resident #2); failed to inform the physician of a with injury for 1 of 3 residents (Resident #1); failed to document the status of wounds for 2 of 3 residents (Resident #1 and #3) and failed to document the condition of 2 of 3 residents (Resident #1 and Resident #2) readmitted to the facility after a hospital stay.

The Findings Include:
1) On at 10:00 AM a request was made to the Licensed Practical Nurse (LPN) Administrator to review the record for Resident #1. A chart with numerous loose pages was produced by the LPN Administrator.

Review of Resident #1's record revealed he was admitted to the facility on / with a diagnosis of , , agitation and history of . Resident #1 expired in the facility on .

Documentation on a white sheet of paper dated / / at 8:30 AM written by the ALF Administrator states, 'Staff reported: Resident attempted to get out of bed forward and bumped his forehead on the wheelchair. Resident sustained a (hematoma) to the forehead. Skin was intact area was reddened on assessment. Message left on MD service.

Additional documentation on another white sheet of paper dated / / at 8:30 AM written by the ALF Administrator states, 'Resident leaned forward attempting to get OOB (out of bed), he forward hit his forehead on the wheelchair. Sustained a bump to the site (hematoma). Skin was intact but the site reddened. Message left on MD voice mail.'
Further review of the resident's record revealed no evidence of documentation regarding the resident's status post sustaining a head injury on /. There was no evidence of documentation the physician responded to the LPN's message left on the voicemail.

Review of an Incident Report dated / completed by the LPN Administrator documents at 8 AM

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the resident has a Hematoma ( ) to the right side of his head; it is documented under Treated by Physician circled 'No', message left on service on 11/19/14 at 10 AM.

On 07/23/15 at 10:00 AM an interview was conducted with the LPN Administrator who stated 'when the aide turned her back to get Resident #1's clothes he . She stated the MD was notified and he ordered home health for the . She stated there was no open area to the forehead, just a hematoma and and after a few days it got black.' A request was made to the LPN Administrator on / at 10:00 AM to produce the physician order received on / / for home health services to which she could not locate a physician order for home health written on / . There was no further evidence available for review that the LPN Administrator notified the resident's physician regarding sustaining a hematoma to his forehead after he hit his head on the wheelchair on / .

Review of the Progress Notes dated / documents, 'Home health agency visited and assess resident for management, to left upper arm and to forehead.' There was no further documentation regarding the status of the or the to the resident's forehead which he sustained after falling and hitting his head on the wheelchair on / / .

The next entry on a sheet of white paper, dated / / written by the LPN Administrator states, 'Resident was seen by home health agency for routine care given.' Further review of the record revealed no evidence of documentation where the was, when the occurred or the status of the . There was no evidence of documentation of the status of the resident's head injury.

The next entry on the same sheet of white paper written by the LPN Administrator dated / at 9-9:30 AM states, 'Staff reported: Resident was having breakfast when he started to , seems like he was choking on his food. Staff initiated resident up what was in his mouth. 911 was called. When they arrived resident was not in distress however they decided to take him to the hospital to have him evaluated. Dr. was notified that the resident was going to hospital by 911.' There was no evidence of documentation of the resident's status or status of the forehead hematoma when the resident was transferred to the hospital post choking episode.

Additional documentation on a sheet of white paper written by the LPN Administrator dated / / documents 'Hospital Social Worker called and notify the facility the resident's x-ray shows ....Facility was not aware of the . Hospital obviously notified DCF (Department of Children and Family Services). Police officer came to the facility to get a report on incident concerning the above named resident.'

Review of Progress Notes dated / documents, 'Resident returned to the facility AAO (awake,

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alert, oriented) x 1. Soft collar in place. Skin with multiple . He returned on hospice care.' Further review of Progress Notes revealed no documentation of the location or status of the and no assessment of the resident upon readmission to the facility with regard to the status of the hematoma or any other assessments.

On at 10:40 AM an interview was conducted with the LPN Administrator who confirmed the Social Worker at the hospital on / called to inform her that the resident had a which they discovered on a . She concurred that the was probably done to evaluate Resident #1's head injury which he sustained after his on / . She stated the resident was always on home health as he always had . An inquiry was made regarding the Progress Notes dated / documenting the home health agency visited to assess the resident's and to forehead to which she responded the home health agency came every Monday,Wednesday and Friday and they may have been in the facility for another resident and did an assessment on Resident #1 post . She stated she left a message on the MD service but the doctor claimed he never got the call. She stated the resident did not have any changes in mental status so she did not think that it was necessary to send him to the hospital. She stated there was no order for home health as they were already coming in to look after his multiple . This was a contradictory statement to the interview conducted on at 10:00 AM when she stated the MD was notified and he ordered home health for the . Additionally during the interview on at 10:40 AM she confirmed they did not document any other assessment of the resident until his choking incident on / / . The LPN Administrator confirmed she did not follow up with the MD when he did not respond to the message left on his service on / / . She stated they do not have a policy of what steps to take if the MD does not return a call in a timely manner. An inquiry was made to the LPN Administrator if she was aware of one of the consequences of a head injury could be a hematoma (inside the) and that could have been the reason why when the resident was sent to the hospital on / after the choking incident, they did a of the head and discovered the . The LPN Administrator stated during the interview on / at 10:40 AM she was aware that with a head injury the development of a hematoma is a possibility and she does not know why she did not follow up with notifying the physician when he did not call back.

2) Review of the record for Resident #2 revealed a progress note dated completed by the LPN Administrator stating 'Staff reported that resident used her walker to go to the on her way back slipped and in her . She picked herself up unattended and did not verbalize pain until a few hours after the . MD notified order to send resident to hospital for evaluation and treatment.' There is no evidence of documentation of an assessment of the resident after the unwitnessed . There is no evidence of an assessment of the resident when she was transferred to the hospital for evaluation a few hours after she sustained the . Further review of the Progress Notes dated documents 'Resident returned to the facility. Medication remain the same. In no acute distress at this

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time.' There is no evidence of documentation of an assessment of the resident when she was readmitted to the facility and no evidence of documentation why the resident was not readmitted to the facility until 2 months after she was sent to the hospital on . On at 12:15 PM an inquiry was made to the LPN Administrator about the status of Resident #2 upon return to the facility to which she responded the resident was admitted to the hospital with a , went to a rehabilitation center and then readmitted back to the facility. The LPN Administrator confirmed there was no documentation of an assessment when the resident and no documentation of an assessment when the resident returned back to the facility.

3) Review of the record for Resident #3 revealed she was admitted to the facility on with a diagnosis of , and decline in function. Resident #3 expired in the facility on .

Review of a physician order dated / / states ' (care treatment) spray to the affected area twice daily x 7 days.' There is no evidence of what body part the care treatment was for.

Review of a physician progress note dated / / documents' Presents with with some tissue. The seem to be worsening since the patient last evaluation. heel.' There is no documentation of which heel was affected.

Review of a physician order dated / / documents ' (care treatment) apply to affected area daily.' There is no documentation of what body part the care treatment was for.

Review of the record revealed a notation that home health services were in effect for twice daily injections. There is no evidence of the date the home health services commenced.

Further review of the record dated / revealed a physician order for an air mattress for a diagnosis of with tissue. There is no documentation of where this is located.

Review of a physician order dated / documents a referral to hospice for a diagnosis non-healing . There is no documentaion of where the was located. Resident #3 was admitted to hospice services on .

Further review of the record revealed a home health agency communication note dated / documenting '...patient admitted to hospice. Hospice skilled nurse will do care dressing. We can continue twice a day injections.'

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On 07/23/15 at 1:00 PM an interview was conducted with the LPN Administrator inquiring where the (s) were located on Resident #3 to which she replied she thinks she had a on her left heel and right side. She stated the home health agency was coming in daily to do care plus twice a day for injections but when the resident went on hospice the home health agency just did the injections and the hospice nurse was doing the dressing changes 3 times a week.

On at 1:10 PM a further interview was conducted with the LPN Administrator who stated she did not document the status of the wounds because the home health nurse was taking care of it. An inquiry was made what the wounds looked like to which she responded she had no idea, she was not doing the dressing changes, it was initially the home health nurse and then the hospice nurse that were looking after it.

Class III

0031 Resident Care - Third Party Services

Based on interview and record review the facility failed to ensure coordination of services with third party providers for 3 of 3 resident records reviewed, (Resident #1, Resident #2 and Resident #3) as evidenced by no evidence of documentation for hospice and home health care services for Resident #1; no evidence of documentation of physician services for Resident #2; and no evidence of documentation for hospice and home health care services for Resident #3.

The Findings Include:

1) Review of the record for Resident #1 revealed he was readmitted to the facility after a hospital stay on under hospice services in addition to home health services for care. Further review of the record revealed no evidence of documentation of any hospice progress notes in addition to no evidence of documentation of any home health care services notes.
On at 11:30 AM an interview was conducted with the Licensed Practical Nurse (LPN) Administrator who confirmed the resident was receiving home health services for care for . The LPN Administrator stated she believed the home health nurse visited 5 days a week and the hospice nurse visited 2-3 times a week. An inquiry was made to the LPN Administrator where the were and what they looked like to which she responded she was not sure as the home health nurse did the dressings. An inquiry was made to the LPN Administrator what the hospice nurse did when she visited to which she responded she thinks they did an assessment of the resident. A request was made to the LPN Administrator to review the home health agency home chart and the hospice home chart to which she responded the home health and hospice nurses took all the notes with them so they do not have anything from them in the facility. An inquiry was made to the LPN Administrator how

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services and communication was coordinated between the home health nurse and the hospice agency to which she responded they would always tell them about their assessments of the resident however she stated they did not write anything down in the resident's record.

2) Review of Resident #2's record revealed she was admitted to the hospital on after sustaining a and was readmitted to the facility on after a rehabilitation stay. Further review of the record revealed the last physician assessment available for review in the resident's record was dated / . On / at 12:15 PM an interview was conducted with the LPN Administrator who stated the physician usually visits monthly. A request was made to the LPN Administrator to provide the monthly physician assessments from 2014 to current to which she responded 'that will be the last assessment you will see as the doctors come in and take their notes with them.' An inquiry was made to the LPN Administrator how they keep track of the resident's medical progress or decline to which she responded she 'asks the doctors to leave a copy of their assessment but they never do.' Review of the resident's record revealed no evidence of documentation the dates the physician visited.

3) Review of the record for Resident #3 revealed documentation she was receiving home health services as of / for care, however there was no evidence of documentation where the (s) were or what they looked like. Further review of the record revealed a physician order for hospice services dated / . Further review of the record revealed a home health agency communication note dated documenting '...patient admitted to hospice. Hospice skilled nurse will do care dressing. We can continue twice a day injections.' Continued review of the record revealed no further evidence of documentation of home health nursing notes or any hospice nurse notes in addition to no documentation by the facility staff of the status of the resident under hospice services or the status of the (s). On / at 1:00 PM an interview was conducted with the LPN Administrator inquiring where the resident's wounds were and what they looked like to which she responded she thinks there was a on the left heel and right hip. She stated the wounds started before the resident was admitted to hospice services and the home health nurse was coming in daily to do care plus the injections and when she went on hospice the home health nurse just came in to do the injections and the hospice nurse did the care. On / at 1:10 PM a further interview was conducted with the LPN Administrator inquiring about the status of the resident's wounds to which she responded 'I did not document about the because the home health agency was taking care of it. I have no idea what the wounds looked like, home health was doing the dressing changes and they took their notes with them.' She further stated the home health nurse was doing the dressing changes daily and when the resident was started on hospice, the hospice nurse changed the dressings 3 times a week. A request was made to the LPN Administrator to review the home health and hospice home records to which she responded 'Both hospice and home health took their notes with them so I cannot tell you for sure what day they all started or what the status of the (s) were.' Further review of the resident's record revealed no observation notes from facility staff documenting the

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status of the resident's (s) or hospice care and services provided.

Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on interview and record review the facility failed to initiate a potential adverse incident report following the diagnosis of a that was diagnosed during a hospital assessment and evaluation after an unrelated incident for Resident #1.

The Findings Include:

Review of the record for Resident #1 revealed he had an unwitnessed on / / , hit his head on his wheelchair and sustained a hematoma to his forehead.

On at 10:00 AM an interview was conducted with the Licensed Practical Nurse (LPN) Administrator who stated Resident #1 had a on / / , sustained a hematoma to his forehead, and after a few days it got black. The LPN Administrator stated she called the physician and left a message on his service however the physician did not return the call and she did not follow up with notifying the physician of the resident's head injury.

Review of the incident report completed by the LPN Administrator dated / / documents the resident sustained a hematoma ( ) to the right side of his forehead after a . There is no evidence of documentation of a head to toe assessment to include an assessment of the resident's neck area. Review of the resident's record revealed no further documentation or assessment of the resident between / and / / .

Further review of the resident's record revealed on / he had a choking episode and was transferred to the hospital for evaluation and treatment. Resident #1 still had evidence of the forehead hematoma which prompted the hospital staff and Social Worker to contact the local police and the Department of Children and Family Services (DCF) to investigate the injury.

Review of documentation by the LPN Administrator dated / / documents 'Hospital Social Worker called and notify facility the resident's x-ray shows . I explained that when he there was no discernable change in his status, there was no or at the site (of the neck). Facility was not aware of the . Hospital obviously notified DCF; city police officer came to the facility to get a report on incident concerning the above named resident.' There is no evidence an adverse incident report was filed with the State Agency after the local police were contacted by the

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hospital Social Worker and after an investigation was completed by law enforcement.

Review of documentation by the LPN Administrator dated 11/27/14 documents, 'A call from the hospital social worker informed the administrator that a result says resident has a C6 . Administrator explained to social worker resident was admitted to ALF status post hip and diagnosis of risk for . A was never done despite all the frequent that he had. This can only be detected by . There is no proof that this is recent or old.'

Review of documentation by the LPN Administrator dated / states, 'DCF officer came to the facility to see resident, states he was here on complaint investigation.'

Review of documentation by the LPN Administrator dated / states, 'AHCA out to see resident.'

Review of documentation by the LPN Administrator dated / states, 'DCF representative visited resident requesting documentation for hospital visit of / .'

On / at approximately 1:30 PM an interview was conducted with the LPN Administrator who confirmed she did not file an adverse incident report because she felt it could not be proven that Resident #1 sustained the as a result of the on / . She stated the only way it could be detected was with a . The LPN Administrator confirmed she left a message for the physician on / however he never returned her call and she did not follow up with a call back to advise of the resident's and subsequent forehead hematoma. She did concur that had she followed up with the physician and had the resident been assessed after the on / , a determination could have been made at that time if the was related to the and had it been confirmed on / an adverse incident report would have been warranted.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Paradise Villa Retirement Home At Pembroke Pine
1145 NW 92nd Avenue
Pembroke Pines, FL 33024

RE: CCR #2015004155

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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/dmb
XG90

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