STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967591	09/03/2015
NAME OF PROVIDER OR SUPPLIER A & L HEALTHCARE, CORP #3	STREET ADDRESS, CITY, STATE, ZIP CODE 4470 CORAL SPRINGS DRIVE CORAL SPRINGS, FL 33065	

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

0000 Initial Comments

An unannounced licensure complaint survey, CCR#20150006037, was conducted on 09/03/2015 and completed on 9/21/2015 at A & L Healthcare. The facility had deficiency found at the time of the visit.

0010 Admissions - Continued Residency

Based upon interviews and record reviews, it was determined that the facility failed to make an adequate pre-admission assessment of the level of care and services required by 1 of 4 residents reviewed for appropriateness of admission and continued residency in the facility, thereby leading to a delay in obtaining a higher level of care for a resident.
The findings include:
Resident #1 was admitted to the facility on with diagnoses to include (difficulty swallowing), and
A review of Resident #1 ' s Resident Health Assessment for Assisted Living Facilities, completed on / , revealed that the Resident required assistance with ambulation, bathing, dressing, self- care, toileting, and transferring. The Resident required supervision for eating. On page 2, section B of the form, the Resident had special diet instructions of " pureed food with nectar thickened liquids ". Page 4, section B of the form indicated that the resident required assistance with the self-administration of medications.
During a interview, the assisted living facility (ALF) Manager stated that Resident #1 had originally been scheduled to be admitted to the ALF about a week earlier, but the Resident ' s family member had canceled the admission and taken the Resident home to celebrate a religious holiday. The Manager further stated that the Resident ' s family member had " shown up " at the ALF on / stating that she could no longer care for Resident #1 and wished to leave her in the care of the ALF. The Manager admitted that although she was aware that the Resident had been in a nursing and rehabilitation facility, she (the Manager) had not obtained or reviewed the Resident ' s discharge orders from the rehabilitation facility. The Manager also confirmed that she was aware that the Resident ' s Health Assessment for Assisted Living Facilities form indicated that the Resident was to receive services from a home health agency (HHA), but she had never received or reviewed the orders for HHA services because the Resident ' s family member never gave them to her. The Manager admitted that she had not followed up with the nursing and rehabilitation center before or after accepting the Resident for admission to the ALF, in order to assure the provision of the level of services required to meet the care needs of Resident #1.
Review of Resident#1's discharge instructions from the facility were obtained and reviewed on / . Prior to being admitted to the Assisted Living Facility, the Resident was treated as a skilled services inpatient at a nursing and rehabilitation center, from which she(Resident #1) was discharged to the care of family members on / . The discharge instructions revealed the following; upon discharge home

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on 04/06/15, the Resident had special needs to include turning/repositioning every 2 hours. The Resident ' s skin was intact, unreddened, and . At discharge, the Resident required moderate to with activities of daily living. Follow-up care by a home health agency (HHA), to include physical , occupational , visits by a nurse, and visits by an aide for assistance with activities of daily living was arranged by the Resident ' s health insurance provider prior to discharge. A physician ' s order dated / reads as follows- "discharge from skilled rehab to home on . Home health orders- , OT, RN eval, and HHA. Cancel discharge to ALF for . " This discharge date is eleven days prior to the Resident ' s admission to the ALF.

On / / , the Surveyor requested and received treatment records for the period of / to / from the HHA that was contracted to provide services for Resident #1 while the Resident was at home with family members. The HHA ' s physical evaluation form dated / lists the Resident ' s skin condition as "Intact " . An oral temperature of 97.6 degrees was also recorded. A review of the HHA records revealed that although the Resident received home visits for services, the Resident refused skilled nursing services on / / at 9:15 AM. A follow-up telephone call to the HHA confirmed that Resident #1 had refused to be seen by the HHA nurse, and was not seen by a nurse during the time she (Resident #1) was at home. Therefore there was no assessment of the Resident ' s medical status or needs on record. A / summary of Care Note by the HHA RN states the following "Patient has been transferred to a facility for rehab and has been discharged from home health services "

On / / , Resident #1 was admitted to the ALF from the care of her family member. A facility Nurse ' s Note entry dated and signed by the facility Manager, who is also a licensed practical nurse (LPN), includes the following- " blanchable redness noted to and bottom. No open wounds noted. (patient) wears diapers, ambulates, and is able to make needs known, will continue to monitor resident. " The Manager further noted that the Resident ' s family member wished to retain the Resident ' s prior health care provider in lieu of using the facility ' s house provider.

During a interview with the Manager/LPN, she was asked to define blanchable redness. The Manager stated that " blanchable is not red to the extreme that you could call it a bedsore or anything like that. Not excruciating " The surveyor asked what happened if the reddened area on Resident #1 ' s bottom was pressed with a finger, to which the Manager/LPN responded " Some of the areas were white, some if you pushed on it you could still see redness "

On / / the Manager made the following entry on the Resident ' s Nurse ' s Notes- " Resident assessed blanchable redness to peri area and bottom. Protective barrier cream applied with diaper change "

On , the Manager made an entry to the Resident ' s Nurse ' s Notes which included the following- " Inform (family member)of blanchable redness to bottom and inner and that protective barrier cream is being applied and that staff and myself is monitoring the area. I inform daughter that mother needs to see a doctor as staff reported she can be stubborn at times and refuses care sometimes "

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A 09/03/2015 interview with Staff #A revealed that she had helped to care for Resident #1 while she was at the facility. She stated that when the Resident came to the facility, the Resident had a quarter-sized spot on her that was " open, red, and when she came in " . The surveyor asked Staff A whether the open area had gotten worse during the Resident ' s stay at the facility, to which Staff A responded "Yes". That ' s why (Manager ' s name) sent her out " . This is in conflict with the Manager/LPN ' s charting. Staff #A further stated that the Resident became restless and and often refused care. She stated that the Manager/LPN had to have two staff present one night during Resident #1 ' s stay because the Resident was refusing to lie down to get pressure off of her . Staff A stated " maybe she was ' " . Staff #A stated that when she returned to the facility from two days off, the Resident ' s condition had continued to get worse, and the Manager/LPN decided to call 911. Staff # A was asked if she was aware of anyone checking Resident #1 ' s temperature when she was at the facility. Staff #A stated that she had not seen anyone do so.

A telephone interview with a former employee of the facility (Staff #B) who had been the primary caretaker for Resident #1 was conducted on . The staff member stated that the Resident was able to go to the table to eat when she arrived at the facility. She stated that the Resident liked to eat cereal and drink juice. This is in conflict with the Resident ' s ordered diet of pureed foods with nectar thickened liquids.

On the Manager documented that Resident #1 was restless, had foul smelling , and that the Manager had informed the Resident ' s family member that the Resident needed to see a medical doctor " ASAP " . There is no documentation of the Manager /LPN directly seeking a higher level of care for the Resident in her care based upon her concerns. On the Manager documented that the Resident was refusing care and " was not looking good " . The Resident was transferred to a hospital per Emergency Medical Services.

Review of Resident #1 ' s hospital records revealed that the Resident presented to the emergency / with a temperature of 101.8 degrees Fahrenheit. She was also found to have a count of 22,000, which is more than twice the upper limit of normal. The Resident was found to have a severe and to her . The Resident was noted to have suffered an apparent , but was not a for " clot buster " treatment for the , as the Resident ' s symptoms had occurred more than four hours prior to her (Resident #1) being transferred to the emergency . The Resident was transferred to the in poor condition for Treatment with and further evaluation and treatment of symptoms.

A study ( ) revealed that the Resident had suffered a large acute infarct (a). Due to her poor prognosis, the Resident was discharged from the hospital to hospice care on .

During a follow-up interview with the Manager on / , she reiterated to the Surveyor that she made numerous contact attempts to Resident #1 POA regarding her current condition and the need for her to see her private healthcare provider. She stated the family keep stating they would make an appointment but they never follow-up.

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Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
A & L Healthcare, Corp #3
4470 Coral Springs Drive
Coral Springs, FL 33065

RE: CCR #2015006037

Dear Administrator:

This letter reports the findings of a State Licensure Survey that was conducted on , 2015 and concluded on , 2015 by a 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than 15, 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/jw
Enclosure

XG90

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