STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932589	**09/29/2015**
NAME OF PROVIDER OR SUPPLIER **GARDENS OF PORT ST. LUCIE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1699 SE LYNGATE DRIVE** **PORT SAINT LUCIE, FL 34952**	

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

0000 Initial Comments

An unannounced licensure complaint survey, CCR# 205007087 was conducted on 09/29/2015 at Gardens of Port Saint Lucie Assisted Living Facility. The facility had deficiencies found at the time of the visit.

0008 Admissions - Health Assessment

Based on resident record review and staff interview, the facility failed to ensure the facility health assessment (AHCA Form 1823) was completely filled in , for 1 of 3 residents whose records were reviewed (Resident #2).

The findings include:

Resident Record review for resident #2 having returned to the facility from the hospital had an updated Health Assessment Form (AHCA Form 1823) dated that was found to be incomplete.

Resident #2 was admitted to the facility on . The facility health assessment (AHCA Form 1823) for Resident #2, dated / , documents diagnoses of A-fib, , , , , chronic left knee pain, chronic left hip pain. The physician indicated that the resident requires total care to meet his activities of daily living needs. The physician indicated the resident left leg is contracted and the resident has and is . The physician indicated the resident is on a regular diet full liquid.

The Health Assessment form dated / has omissions. Page 1 the question of whether or not the resident is an elopement risk is blank. Page 2 section C the physician indicated that the resident is bedridden and is total assist; page 2 section D is left blank it does not document if the residents needs can be met in an assisted living facility. Page 4 section A, the medication list is blank; section B is blank and does not document whether the resident needs help with taking his/her medications; section C, the physician did not include his signature, medical license # address or telephone number. Page 5 is blank and does not document the services offered or arranged the facility for the resident.

During interview with The Resident Care Director on at 3:35 PM, he acknowledged the missing information on Resident #2's AHCA Form 1823.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932589	09/29/2015
NAME OF PROVIDER OR SUPPLIER **GARDENS OF PORT ST. LUCIE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1699 SE LYNGATE DRIVE** **PORT SAINT LUCIE, FL 34952**	

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

0010 Admissions - Continued Residency

Based on record review, interview and observations, it was determined that the administrator failed to monitor the continued appropriateness of placement of a resident, for 1 of 3 residents records reviewed (Resident #2).

The findings include:

Record review of Resident #2's record revealed an admission date of . A review of Resident #2's Health Assessment (AHCA Form 1823) dated / documented diagnosis as A-fib, , , chronic left knee pain and chronic left hip pain. Physical or sensory limitations documented left leg contracted. or behavioral status documented as ( ). Special precautions noted as risk. The resident's Activities of Daily Living (ADLs) are documented as total care for ambulation, bathing, dressing, self- care, toileting and supervision with eating Further review of Resident #2's AHCA Form 1823 documents the resident requires a liquid diet in liquid form.

Review of the resident service- level of care notes dated revealed the following. The resident needs physical assistance on a regular basis, or prompting to vacate the building in an emergency. The resident is a risk. The resident needs physical assist on a regular basis. The resident is able to bear weight during transfer. The resident needs physical assist in toileting needs. The resident needs continuous supervision, monitoring of food/liquid intake and/or monitoring of swallowing problems. The resident has severe , requires constant redirection and monitoring. The resident requires assistance with oral medication assistance /administration up to 2 times a day.

Review of the residents record revealed he was assessed for hospice services on it was determined at that time that the resident was not appropriate for admission to hospice.

Observations of the resident on at 3:00 PM revealed the resident was just assisted to bed to rest. He was laying on his left side. Two staff had just exited the stated that they just assisted the resident to bed. The resident was alert to person only.

Random interviews with staff members on revealed the resident requires a two person assist to transfer. The resident is generally and helps as much as he can. The staff feed the resident his meals. The food is pureed. He is able to assist in bathing and dressing by lifting his arms and sitting forward. The resident ' s medications are crushed and administered by the Nurse.

During an interview with the Resident Care Director on //15 at 2:30 PM, he stated the resident

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932589	**09/29/2015**
NAME OF PROVIDER OR SUPPLIER **GARDENS OF PORT ST. LUCIE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1699 SE LYNGATE DRIVE** **PORT SAINT LUCIE, FL 34952**	

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

requires two people assist for transfer but can bear weight. The resident is not bead bound. He gets up for his meals and is positioned in a wheel chair or other chair when out of bed. Resident Care Director stated further that the 1823 dated / was completed after the resident had been hospitalized and that the resident had improved significantly since readmission on . The Resident Care Director did not feel the 1823 was a true reflection of the resident ' s condition at this time.

During an exit interview, the Resident Care Director acknowledged that the Facility Health Assessment Form (AHCA From 1823) is incomplete. He acknowledged that it is not a true reflection of the residents needs at this time. He stated that the facility plans to have the resident immediately evaluated by his physician. He also confirmed the resident is not currently receiving hospice services.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

', 2015

Administrator
Gardens Of Port St. Lucie
1699 SE Lyngate Drive
Port Saint Lucie, FL 34952

RE: CCR #2015007087

Dear Administrator:

This letter reports the findings of a complaint 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 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 22, 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
Enclosure
XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida