STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967718	09/22/2015
NAME OF PROVIDER OR SUPPLIER LEISURE LIVING OF VICTORIA PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 NE 5TH STREET FORT LAUDERDALE, FL 33301	

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

0000 Initial Comments

Unannounced licensure complaint surveys, CCR #2015006167 and CCR #2015006747, were conducted on 09/16/2015 through 09/22/2015 at Leisure Living of Victoria Park. The facility had deficiencies found at the time of the visit.

0010 Admissions - Continued Residency

Based on observation, interview, and record review, it was determined that the facility administrator failed to adequately assess 1 of 5 residents reviewed for appropriateness of admission. The administrator agreed to re- admit a Resident (Resident # 1) to the facility without first determining the level of care and services the Resident would require , thereby admitting a Resident without knowledge that the Resident had a on her sacrum.

The findings include:

Resident # 1 was initially admitted to the assisted living facility from a rehabilitation facility on , with diagnoses to include , history of and skin , and a history of .

1) On , Resident #1 suffered a in the facility and was transferred to the hospital, where she underwent surgery to repair a broken hip. The Resident was discharged from the hospital to a rehabilitation facility where she stayed until . A / / review of the discharge summary from the rehabilitation facility reveals that on the Resident required total assistance with activities of daily living (ADL) and care.

a) During a / interview, the assisted living facility (ALF) Administrator admitted that she was unaware of the Resident ' s care and ADL needs when she re-admitted the Resident to her facility. In the course of the same interview, the surveyor asked the Administrator how she had determined that the Resident was appropriate for re-admission to the ALF. The Administrator admitted to the surveyor that she had not spoken to anyone at the Rehabilitation facility about the Resident ' s condition or care needs, nor had she requested or reviewed any rehabilitation facility records in order to determine whether her facility was an appropriate placement for the Resident.

b) A review of the rehabilitation facility discharge summary for Resident #1 revealed that the discharge summary lists "requires care" under the Special Treatments and Procedures section.

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c) The ALF Administrator stated that while providing incontinence care for the Resident on the same day that the Resident was re-admitted, she noticed that the Resident had a on her sacrum. The administrator stated that she then called the house physician and described the .

The Administrator stated that the physician told her that she had described a on the Resident ' s sacrum, and gave orders for her (The Administrator) to contact a home health agency to care for the Resident ' s . The Administrator confirmed that she failed to discharge the Resident to a higher level of care.

2) A review of Home Health Agency and facility records revealed the following:

a) The Resident received care from 2 different Home Health Agencies between the dates of and / . A / Physician ' s visit note by the facility physician reads as follows- "I was called to evaluate sacral with discharge and odor. is deep and . in progress. " Orders for daily treatment of a " -4 sacral " were written. The facility Administrator was unable to produce documentation that care was provided every day as ordered by the facility physician.

b) On / the facility physician wrote the following order- " clean right hip with (illegible) and apply TAB and cover with nonstick sterile dressing and seal with paper tape qd (every day). The physician also wrote an order for the Resident to have a hospital bed with and air mattress for the diagnoses of lower extremity and a sacrum . Supporting documentation was obtained by the surveyor.

c) On the facility physician wrote an order for 250 milligrams 1 gel cap for 6 weeks, as well as an order for a culture. is an that is used to treat in the skin among other uses.

d) On Resident #1 was seen by an physician and was diagnosed with " of sacral ".

e) Among the orders written by the physician was an order for ( ) and placement of a vac. At this point, the Administrator made the decision to notify the family that the Resident would be discharged to a higher level of care. The Resident was discharged to a rehabilitation facility to undergo the ordered treatment regimen.

f) On the Resident was discharged from the rehabilitation facility back to Leisure Living of Victoria Park. The Resident Health Assessment for Assisted Living Facilities form completed by the

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rehabilitation facility on 08/26/15 indicates that Resident #1 had a sacral and a Right hip

3) The Resident was again re-admitted to the assisted living facility and placed on hospice services on

a) At the time of the complaint investigation visit to the facility, neither the facility Administrator nor the hospice agency were able to provide documentation that the Resident has been seen by hospice nurses every day despite an physician ' s order for daily dressing changes.

b) On at 5:15 PM the registered nurse surveyor observed care for Resident #1. The surveyor observed that when the Resident's leg was moved the joint movement could be seen inside the due to the size and depth of the .

Class III

0031 Resident Care - Third Partv Services

Based on record reviews and interviews, it was determined that the facility failed to assure coordination care and services between the assisted living facility and the hospice agency providing services to 1 of 1 residents reviewed for coordination of services.

The findings include:

1) Resident # 1 was initially admitted to the assisted living facility (ALF) from a rehabilitation facility on , with diagnoses to include , history of and skin , and a history of . On , the Resident was sent to a hospital after a in the ALF which resulted in the Resident fracturing her hip. The Resident underwent surgery to repair her hip, and was discharged to a rehabilitation facility where she resided until . The Resident was re-admitted to the ALF with increased care needs which included total assistance with the activities of daily living and care. (Refer to ST-A0010)

2) A review of facility records revealed the following:

a) On , the same day that the Resident was re-admitted to the ALF, the Administrator noted that the Resident had a on her sacrum. The Administrator contacted the physician who instructed the Administrator to contact a Home Health Agency for care. On / Resident #1 was seen by an physician and was diagnosed with " of sacral ' " . The

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physician ordered a six week course of and use of a vac to treat the Resident ' s , thereby requiring the Resident to be transferred to a rehabilitation facility which could offer a higher level of care.

b) On the Resident was discharged from the rehabilitation facility back to Leisure Living of Victoria Park. The Resident Health Assessment for Assisted Living Facilities form completed by the rehabilitation facility states on page 2, section C that Resident #1 has a sacral and a Right hip . The Resident was again admitted to the assisted living facility and placed on hospice services on .

c) On , the same date that the house physician wrote an order to admit Resident #1 to hospice care, the physician wrote an order as follows- " Cleanse with NS (normal); apply with cream to (right) hip. Cover with 4 by 4 gauze and dressing (an absorbent dressing) daily until healed. Cleanse with NS apply packing with alginate dressing. Change every day until healed.

d) Review of hospice notes left at the facility revealed that there was no documentation of visits by a nurse to provide care on 10 separate dates between the between the time the Resident was admitted to hospice and the surveyor visit to the ALF. On at 4:36 PM the hospice agency provided documentation of visits for six of the ten dates. No documentation of care was provided that care was provided for Resident #1 on , , , or .

e) The surveyor further noted the following entries included by a hospice nurse in the hospice provider ' s Narrative .

Notes-
1) - " Removed adult brief. Chux (under) saturated with ...Caregiver (name) present. Educated on skin care and frequent brief changes to promote healing process ....Report to case manager "
2) - " Removed adult brief with large amount of ...no dressing to "
2:15 PM- " No dressing found on to "

3) On at 2:15 PM, Resident #1 ' s hospice agency RN Case Manager was interviewed by telephone. When the Case Manager asked about the above entries she stated " Our nurse wrote that? " The RN Case Manager was asked what had been done to address the Resident's being found without a dressing and exposed to the Case Manager stated " She (Resident #1) needs a . " The Case Manager stated that the facility staff could call the hospice agency and request that e nurse come to replace a soiled dressing or a dressing that has off. Neither the

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hospice agency nor the facility was able to produce documentation that ALF staff have ever contacted the hospice agency regarding a soiled or missing dressing.

4) Review of facility and hospice records at the facility revealed that there was no visit, sign-in or communication log showing any entries in place at the facility to document hospice staff visits to the ALF to provide services for Resident #1. During a 5:58 PM interview with the ALF administrator and the hospice nurse, the nurse stated that the log might have been removed by a hospice employee because the " page was full ".

5) During a 10:00 AM telephone interview, the Administrator was asked to provide the facility policy regarding how the ALF will coordinate services with third party providers. The Administrator stated that the facility has no such policy in place.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interviews, the facility failed to maintain an environment that is safe and home-like for 1 of 14 residents who reside at the facility (Resident #2).

The findings include:

During the morning tour of the facility on at around 9:00 AM, it was observed that the facility had placed in the hallway, on the East side of the property, seven leathered chairs that were noted be ripped and in disrepair.

During an observation on at 9:30 AM in Resident #2's was noted that the wall inside the the resident's bed head board and night stand was ripped from the ceiling down to the level of the head board. The plaster on the ceiling was partially broken, and the paint on the wall next to the resident's night stand was peeling off.

During an interview with the administrator, she reported that there were repairs pending to be done in that the facility. She indicated that the Assistant Administrator was designated to complete these repairs.

During an interview with the Assistant Administrator on / at 5:35 PM, he said that he had in mind to do the repairs about three weeks ago, he had no work order for the pending repairs and no documentations to prove that the repairs were in the process of taking place. When asked meanwhile,

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neither the administrator nor the Assistant Administrator was able to state with certitude how long the resident's wall and ceiling has been dilapidated.

During an interview with Resident # 2, he reported that he has been living at the facility for about two years. He reported that he is legally and acknowledged that he was not aware of the wall's condition.

Class III

0161 Records - Staff

Based on record review and interview, the facility failed to prove that 1 of 3 sampled employees (Employee A) had completed all the required trainings. As evidenced by these records being missing from the employee's file, and the facility's failure to make them available for review upon request.

The findings include:

During the employee's record review, it was noted that employee A's file was not complete. Many necessary training documentation and certificates required were missing. During an interview with the Administrator on at 11:30 AM, she reported that the employee was hired from a sister facility and that some of the records were still over at the other facility. She indicated that she would have them faxed over. However, only the employee's background information and health assessment were submitted.

Review of Employee A's file revealed that the following trainings were not in the file:

Elopement training, incident reporting, control, emergency preparedness & evacuation training, resident's rights training, recognizing/reporting , neglect and training, P& P training and medication training were all missing.

During a follow-up interview with the Administrator later that same day, she affirmed that Employee A a certified nursing assistant, also not verified, assist residents with medication self-administration.

Upon leaving the facility on / at 5:28 PM, the Administrator did not provide the needed information as she had promised she would.

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0162 Records - Resident

Based on record review and interview, the facility failed to have 1 of 3 sampled residents' health assessment (Resident #3) readily available upon request.

The findings include:

During review of Resident # 3 records, it was noted that the health assessment (AHCA form 1823) was missing. The resident's diagnoses and health status information were collected from the resident ' s Face Sheet and from his hospital record which indicated that he was taken to the Emergency

Observation of Resident #3 on / at 11:30 AM revealed that he was nicely , appropriately attired. An attempt to interview him indicated that he lacked the ability to maintain a conversation even in his native tongue. An attempt to review Resident #3's health assessment was not possible, it was not available to be reviewed. The file was missing.

During Resident #3 ' s record review, on / at 1:05 PM, it was noted that the resident was admitted to this facility on with the following diagnoses: , , and (retrieved from the Face sheet). Further review of the record revealed that the resident's health assessment (AHCA form 1823) was missing.
During an interview with the Administrator on at 1:12 PM, she affirmed that Resident #3 had a ; however, she did not have any documents to verify whether the incident was investigated and what had happened. She also said that she did not know what happened to the resident's health assessment.

During an interview with employee (B) and (C) on the same day and at 2:02 PM and 2:14 PM respectively, they both reported that no residents to their knowledge at the facility. However, Employee (B) indicated Resident #3 requires assistance of two persons for transfer and his toileting needs.

Another interview with the administrator at 3:22 PM contradicted her initial statement as she reported that none of her residents has had any at the facility. She reported that she has been able to solve the issue of " " by creating an incentive program for her employees, in which a history of no for an unknown period of time would be rewarded accordingly.

Following the reviewing of Resident #2 ' s hospital record it was noted that the resident at the facility on at 12:19 AM, the resident was transported via ambulance to and treated at Broward Health

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Medical Center subsequent to the . The record indicated that the resident sustained a head injury. But, he was discharged from the hospital back to the facility on 6/13/15 at 4:50 AM with recommendations to follow-up with his primary physician.

During a follow-up interview with the Administrator regarding this at 4:51 PM, she reported that she did not remember that the resident . She said that every time something happens to the residents, she immediately notifies the family members. However, she had no documentation to validate the claim that either the family member was contacted or that an investigation was done to find out the cause of the . Additionally, she was not able to verify whether she had filed an adverse incident report.

A final interview with the Administrator indicated that she was not sure about what had happened with any of her documentations regarding this incident.
The administrator stated on at 4:51 PM, that she did not know what had happened to the record. At the exit at nearly 5:30 PM, the administrator was still not able to provide the document.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Leisure Living Of Victoria Park
1700 NE 5th Street
Fort Lauderdale, FL 33301

RE: CCR #2015006167 & CCR #2015006747

Dear Administrator:

This letter reports the findings of complaint surveys that were conducted on , 2015 through , 2015 and , 2015 by representatives 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 , 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 representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure
XG90

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