STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968395	**10/23/2015**
NAME OF PROVIDER OR SUPPLIER **AVON MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **4531 SW 34TH STREET FORT LAUDERDALE, FL 33312**	

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

0000 Initial Comments

An unannounced Assisted Living Facility complaint survey (CCR#2015010973) was conducted on 10/16/15-10/23/15 Avon Manor, had deficiencies found at the time of the visit.

0030 Resident Care - Rights & Facility Procedures

Based on record review and interview, it was determined that the facility failed to ensure residents reside in a safe living environment free from and neglect for 1 of 3 (Resident #1) records reviewed. This was evidence by the facility staff's failure to implement their own Incident Reports Policy as related to violation of resident rights, and neglect and to report to law enforcement and the hotline all incidents related to and neglect for all residents residing in the facility. Furthermore the facility failed to implement a plan to ensure the safety of the residents during the course of the investigation of the allegations.

The findings include:

Record review of the facility's undated policy titled, " Incident Reports " , reveals:
Injuries and unusual incidents will be reported in compliance with state regulatory requirements.
The unusual incident form is used to document and report any incident which is a threat to a resident's health, safety, welfare, or rights. This includes, but is not limited to occurrences such as; all violation of resident rights.
All incidents related to , neglect, assault or , are reported to the ombudsman, state licensing agency, and in the case of assault (physical or) to law enforcement.

Resident #1 was admitted to the facility on / / , with a diagnosis that includes: , hormone deficiency, , and D deficiency. Her AHCA form 1823 revealed that she has limitation in her gait, uses a cane, is and is on precautions.
In an interview conducted on / at 3:10 PM with the Administrator, he stated that he first became aware of an allegation of against Resident #1 around the time when she sustained a above her left eye. Which was in 2015, he could not give an exact date, and he confirmed that he did not have any documentation of an investigation. He stated that a former staff member told him that a former resident told her that Staff C was abusing Resident #1. He states that he asked the former staff member, if she had witnessed it personally and she denied it. He stated he did nothing further and Staff C continued to work at the facility with all the residents.
A review of Resident #1 ' s record revealed no progress notes.
A review of the facility's log book revealed the following:
On / Resident #1 was found with a on her left eye area. Staff C/ aide reported that resident

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slipped and on the floor after spilling her . Urine was observed on the floor, note entry signed by the administrator.

In an interview conducted on / at 2:12 PM with Staff C, she stated that on / Resident #1 got up in the night, she heard her screaming, and went and checked on her. At that time she found there was on the floor and resident had on her eye, she got ice, informed the administrator when he came in. The Administrator came in the morning before 8 AM.

A written statement received by the Administrator on , reveals the following: the allegation of was made by a resident to an aide who in turn brought it to my attention. That aide has since separated from employment with this facility. The aide reporting that the former resident saw Resident #1 being abused by another aide did not report witnessing the firsthand to me at any time. This series of events came about when Resident #1 presented with a dark blue above her eye. The aide assigned to her when the occurred promptly brought the matter to my attention and reported that she was found on the floor with spilt about. Resident #1 could walk around, and indicated that she slipped on the floor and banged her head. A preliminary assessment found that resident could walk around unaided without pain. The was reported to the physician and the family and a summary recorded in the log book.

Class III

0078 Staffing Standards - Staff

Based on record review, observation and interview, the facility failed to ensure 1 of 3 (Staff B) current staff members have evidence of an annual negative ( ) exam, and 1 of 3 staff (Staff C) failed to have a statement from a health care provider that the individual does not have any of signs and symptoms of a communicable no earlier than 6 months prior to submission.

Findings included:

a) A review of Staff B's personnel record, whose date of hire was , lacked documentation of an annual negative ( ) exam. The last documented negative exam was dated .

In observations conducted on / / throughout the day, Staff B was observed directly interacting with the residents and assisting the residents at times.

b) A review of Staff C's personnel record, whose date of hire was , revealed that the only

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statement that the staff does not have any of signs and symptoms of a communicable was dated 4/20/14, which was approximately 10 months prior to her date of hire.
In an interview conducted on at 2:12 PM, Staff C states that she has been employed since in her duties she passes medications, assists the resident with their activities of daily living, as well as laundry, cooking and cleaning the facility.
A review of the facility ' s posted schedule for the month of 2015 revealed that Staff C is the only direct care staff scheduled to work on Sundays, Mondays and Tuesdays.

In an interview with the Administrator on / / at 1:09 PM, he reviewed the file and confirmed the findings.

Class III

0081 Training - Staff In-Service

Based on record review and interview, the facility failed to ensure that all direct care staff members who are not core trained received the required in-service training within 30 days of employment, for 1 out of 3 (Staff A) sampled employees' records reviewed .

The Findings Include:

1. A review of Staff A's (hire date) personnel file showed the record lacked documentation indicating the employee received the required in service training regarding the facility's resident elopement response policies and procedures.

2. Further review of Staff A's personnel file revealed the record lacked documentation indicating the employee received the required 1 hour in-service training's covering :
a) Reporting major incidents
b) Reporting adverse incidents
c) Facility emergency procedures

3. Staff A's personnel file also showed that the record lacked documentation indicating the employee received the required 1 hour in-service training's in the following:
a) Resident Rights in an Assisted Living Facility
b) Recognizing and reporting resident , neglect and
c) Safe food handling practice

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A review of the facility ' s posted schedule for the month of 2015 revealed that Staff A is the only direct care staff scheduled to work on Wednesdays, Thursdays, Fridays and Saturdays

In observations conducted on throughout the day, Staff A was observed directly interacting with the residents, assisting them to the , cooking lunch and assisting with feeding the residents, completing laundry, and assisting the residents with ambulation.

In an interview conducted on / / at 2:00 PM with Staff A, she stated that her duties include, cleaning, laundry, assisting the residents with their care, cooking and passing medications. She has been working at the facility about 6 weeks. She stated that the administrator trained her on passing medications only.

In an interview with the Administrator on / at 1:09 PM, he reviewed the file and confirmed the findings.

Class

0082 Training - / _ _

Based on record review, observation, and interview the assisted living facility failed to ensure that 1 out of 3 (staff A) current staff members have the required /Aquired Deficiency (/) training within 30 days of employment.

The findings include:

Record review of staff A's personnel record, whose date of hire was , lacked any documentation that staff A completed (/) training .

A review of the facility ' s posted schedule for the month of 2015 revealed that Staff A is the only direct care staff scheduled to work on Wednesdays, Thursdays, Fridays and Saturdays

In observations conducted on / throughout the day, Staff A was observed directly interacting with the residents, assisting them to the , cooking lunch and assisting with feeding the residents, completing laundry, and assisting the residents with ambulation.

In an interview conducted on / at 2:00 PM with Staff A, she stated that her duties include, cleaning, laundry, assisting the residents with their care, cooking and passing medications. She has been working at the facility about 6 weeks. She stated that the administrator trained her on passing

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medications only.

In an interview with the Administrator on 10/16/15 at 1:09 PM he reviewed the file and confirmed the findings.

Class

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on record review and interview, the facility failed to ensure that 2 out of 2 current employees that assist with self administration of medications (Staff A and Staff C) had completed a 4-hour course in assistance with self-administered medications by a licensed registered nurse or a licensed pharmacist.

The Findings Include:

A record review of Staff A ' s personnel file revealed a hire date of , it was noted that the record lacked the required certificate indicating she completed a 4-hour initial training course on assistance with self-administered medication and medication management.

A record review of Staff C ' s personnel file revealed a hire date of , it was noted that the record contained 2 certificates of completion ,(/ / and) indicating Staff C had completed the required 4-hour initial training course on assistance with self-administered medication and medication management, however further review revealed the instructor's signature indicated she was a Licensed Practical Nurse (LPN) and not a licensed registered nurse or a licensed pharmacist as required.

A review of the facility ' s posted schedule for the month of 2015 revealed that Staff A is the only direct care staff scheduled to work on Wednesdays, Thursdays, Fridays and Saturdays and Staff C is the only direct care staff scheduled to work on Sundays, Mondays and Tuesdays.
A review of the Medication Observation Record (MOR) for Resident #1 and Resident #2, showed that the only initials on the MOR for having observed the residents administer their medications corresponded to Staff A and Staff C.

In a side by side interview and review of the MOR conducted on at 11:40 AM with Staff A, she confirmed that those were her initials on the days she worked at the facility.

In an interview conducted on / at 2:00 PM with Staff A, she states that her duties include, cleaning, laundry, assisting the residents with their care, cooking and passing medications. She has

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been working at the facility about 6 weeks. She stated that the administrator trained her on passing medications only.

In an interview conducted on at 2:12 PM, Staff C stated that she has been employed since in her duties she passes medications, assists the resident with their activities of daily living, as well as laundry cooking and cleaning the facility.

In an interview with the Administrator on / / at 1:09 PM he reviewed the file and confirmed the findings.

Class III

0090 Training -

Based on record review, observation, and interview the assisted living facility failed to ensure that 1 out of 3 (staff A) current staff members have the required ( ) training within 30 days of employment.

The findings include:

Record review of staff A's personnel record, whose date of hire was , lacked any documentation that staff A completed training. Record review revealed Staff A did not complete the CORE requirement.

A review of the facility ' s posted schedule for the month of 2015 revealed that Staff A is the only direct care staff scheduled to work on Wednesdays, Thursdays, Fridays and Saturdays

In observations conducted on throughout the day, Staff A was observed directly interacting with the residents, assisting them to the , cooking lunch and assisting with feeding the residents, completing laundry, and assisting the residents with ambulation.

In an interview conducted on / at 2:00 PM with Staff A, she states that her duties include, cleaning, laundry, assisting the residents with their care, cooking and passing medications. She has been working at the facility about 6 weeks. She stated that the administrator trained her on passing medications only.

In an interview with the Administrator on / at 1:09 PM he reviewed the file and confirmed the findings.

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Class

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and interview the facility failed to maintain and file an adverse incident report to the agency for 1 of 3 (Resident #1) records reviewed, for an allegation of .

The findings include:

A review of the facility ' s undated Policy Titled Incident Reports, reveals :
Injuries and unusual incidents will be reported in compliance with state regulatory requirements.
Procedure: The unusual incident form is used to document and report any incident which is a threat to a resident ' s health, safety, welfare, or rights. This includes, but is not limited to occurrences such as : Any violation of resident rights.
All incident related to , neglect, assault or , are reported to the ombudsman, state licensing agency, and in the case of assault (physical or) to law enforcement.

Resident #1 is an female admitted to the facility on / / , with diagnosis that includes : , hormone deficiency, , and D deficiency. Her AHCA form 1823 revealed that she has limitation in her gait, uses a cane, is and is on precautions.

A review of her record revealed no progress notes.A review of the facility's log book revealed the following: Related to Resident #1- Resident #1 was found with a on her left eye area, reported by Staff C that resident slip and on the floor after spilling her . Urine observed on the floor, signed by the administrator.

In an interview conducted on / / at 3:10 PM with the Administrator, he stated that he first became aware of the allegation of against Resident #1 around the time when she sustained a above her left eye. Which was in 2015, he could not give an exact date, as he confirmed that he did not have any documentation of an investigation. He stated that a former staff member told him that a former resident told her that Staff C was abusing Resident #1. He states that he asked her if she had witnessed it personally and she denied it. He stated he did nothing further.

In a written statement received by the Administrator on it reveals the following: the allegation of was made by a resident to an aide who in turn brought it to my attention. That aide has since separated from employment with this facility. The resident that the aide claimed made the allegation was beset with ; a history of hallucination when afflicted with routine ; bad

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eyesight and poor hearing, and who happens to be ninety nine years old and in other wise reasonably good health. To be clear the aide reporting that the resident indicated above saw Resident #1 being abused by another aide did not report witnessing the firsthand to me at any time. Resident #1 the target of this inquiry has acute memory loss, and unsteady gait. This series of events came about when Resident #1 presented with a dark blue above her eye. The aide assigned to her when the occurred promptly brought the matter to my attention and reported that she was found on the floor with spilt about. After questioning by the aide on the scene, resident #1 could walk around After questioning by the aide on the scene, Resident #1 indicated that she slipped on the floor and banged her head. A preliminary assessment found that resident could walk around unaided without pain. The was reported to the physician and the family and a summary recorded in the log book.We consider the accusation of a grave matter which should be tempered with a thorough investigation should a preliminary inquiry require a deliberate review of the events leading up to the formal investigation of the alleged offense. In this case, the witness to the alleged offense was not credible in my estimation but it was decided that the situation warranted continued monitoring to be sure there was nothing on toward occurring. Additionally, when I spoke with the resident who was said to make the allegation of , as part of my initial inquiry, I got a blank response.

In an interview conducted on / at 2:10 PM with the Administrator, he stated that continued monitoring meant if Resident #1 presented with another , scratch or than more investigation would be warranted. He confirmed that he did not file an adverse incident report nor had documentation of an investigation nor did he report the allegation to the hotline.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Avon Manor
4531 SW 34th Street
Fort Lauderdale, FL 33312

RE: CCR #2015010973

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 , 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/dso
Enclosure
XG90

Delray Beach Field Office
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