| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11968935 | 02/23/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**EAST RIDGE RETIREMENT VILLAGE, INC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**19225 SW 87TH AVE**<br>**MIAMI, FL 33157** | |

SUMMARY STATEMENT OF DEFICIENCIES
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**0000 Initial Comments**

A complaint (CCR# 2016000380) survey was conducted from , 2016 thru 23 rd, 2016. East Ridge Retirement Village, Inc. with extended congregate care component had the following deficiencies identified at the time of survey:

**0008 Admissions - Health Assessment**

Based on record review and interview, the Assisted Living Facility failed to have a completed health assessment within 60 days before admission to the facility or within 30 days of admission for two (#1 and #2) out of four sampled residents.

Findings included:

Review of Resident #1 ' s record revealed that admission date was on . There was Health assessment (AHCA form 1823) completed on and the next health assessment (AHCA form 1823) completed on .

Review of Resident #2 ' s record revealed that admission date was on . The only Health assessment (AHCA form 1823) completed on .

In an interview on / at 12:37 PM the Manager revealed that it was the only health assessment that Manager found in Resident #2's record. Manager did not find another health assessment closer to Resident #1 ' s admission date.

Class III

**0010 Admissions - Continued Residency**

Based on record review and interview, the Assisted Living Facility failed to obtain a new health assessment after a significant change in condition for two (#1 and #2) out of four sampled residents.

Findings included:

Review of Resident #1's record revealed that last health assessment (AHCA form 1823) completed on / ; it had in blank resident ' s height and weight. It indicated that resident was wheelchair bound, and disoriented, was under hospice services and had and precautions resident needed assistance with ambulation, bathing, dressing, self-care ( ), toileting, and supervision,

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and supervision with eating, under regular puree diet.
Review of Resident #1's hospice record revealed that Resident #1 received hospice services since . Nursing initial assessment completed on revealed that Resident #1 was wheelchair and needed with mobility, dressing, toileting, transferring bathing. Appropriateness evaluation for hospice completed on by hospice nurse revealed that resident was needed max assistance for bathing, toileting and dressing, and was dependent for transferring (wheelchair).

Review of Resident #2's record revealed that the only Health assessment (AHCA form 1823) completed on . It had in blank resident ' s height, weight, physical or sensory limitations, or behavioral status, nursing/treatment/ service requirements, transferring. It indicated that resident had precautions, a communicable which could be transmitted to other residents or staff and that individual ' s needs cannot be met in an assisted living facility.
Review of Resident #2's hospice record revealed that Resident #2 received hospice services since . Nursing initial assessment completed on revealed that resident needs with mobility, dressing, toileting, transferring bathing. Appropriateness evaluation for hospice completed on by hospice nurse revealed that resident was dependent for bathing, transfer, toileting and dressing.
In an interview on at 12:37 PM the Manager revealed there was not any other health assessment that showed her changed in condition.

Class III

**0025 Resident Care - Supervision**

Based on record review and interview, the Assisted Facility failed to provide adequate supervision to meet the needs of one (#4) out four sampled residents, to follow doctor order for one (#4) out four sampled residents as well as to follow their policy of prevention and management program with one (#4) out of four sampled residents.

Findings included:

In an interview on at 9:57 AM the CNA (certified nursing assistance) B revealed that Resident #4 ' s private aid informed her that Resident #4 had a bump on the back of her head which private aid observed when she was combing Resident #4 ' s hair. CNA B observed Resident #4 ' s head and saw a bump. CNA B contacted the nurse who an evaluation. CNAs assisted the residents with their showers, dressing, eating and taking them to activities.

In an interview on at 10:21 AM the Licensed Practical Nurse (LPN) stated "I was informed

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that Resident #4 had a bump on the back of her head. I did an assessment and she had a light on the back of her head. I suggested doing a X-rays in order to know that she was fine."

Review of Resident #4's record on at 9:45 AM showed that "Services and Amenities provided for the Assisted Living Fee. In consideration assisted Living fee, we agree to provide the following services and amenities for so long as you reside at the Assisted Living Facility: 3.3-Assisted living services (including extended congregate care) in accordance with your written plan of care designed to respond " . 4.2- Personal Services, Personal services such as assistance or supervision of the essential activities of daily living including ambulation, bathing, dressing, eating, and toileting.

In an interview on at 11:00 AM the CNA A stated "Resident #4 wants to be independent. We supervise her in the bathtub. We supervise her showers three times weekly. We offer assistance with the shower three times weekly. Some residents want to receive bath daily and we provide to them."

Review of Resident #4 ' s Treatment Record showed that the resident did not receive assistance with the (Self shower). On 2015 showers on Monday, Wednesday and Friday afternoon from 7-3 PM documented "FYI" (for your information). Care Service Log for and , 2015 did not document that the resident receive any type of assistance with her shower. Health Assessment (AHCA form 1823) completed on / document that the resident needed assistance with her (staff to assist). Section 3 documented that the residents needed assistance with her bathing daily. The service will be provided by the staff.

Review of facility ' s record revealed that facility had in place policy of prevention and management program for emphasizing identification of risk and interventions to minimize to keep the resident safe. Steps following a : 1. Head to toe assessment by a license nurse completed before the resident is moved. 2. Emergency care will be provided to the resident following appropriate procedures. 3. Add event to 24- hour report and share via shift report. 4. The license nurse documents the following at time of ; time of date, description of scene, resident ' s behavior prior to if known, objective statement made by resident, ROM (range of motion), describe resident ' s injury if any, absence or presence of pain, any first aid given or treatment by physician, document ( , ) ' s, pulse, , document where was move after, document signs if head injury is suspected or was unwitnessed, document family and physician notified 5. if a head injury suspected or was unwitnessed, -checks every hour for four hours and then every four hours up to 24 hours and then every shift for 72 hours.8. Documentation for 72 hours will be completed in the Medical Record. 9. The assessment form will be done and maintained in the resident ' s chart.

Review of Resident #4 ' s incident report completed on revealed that Resident #4 few days ago, small on back of head (lower right side) found by private aid with in upper left back.

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Resident stated no pain fine, -check normal and documented , pulse and rate. Documented unknown where, when, how, and who present the .

Review of Resident #4 ' s record revealed that there was just one assessment form and it was completed on at 1 PM.

Review of Resident #4 ' s record revealed that LPN documented on at 2 PM that Resident #4 ' s son was called and was informed that Resident #4 had a , all assessment made; Resident #4 had a in the back (left) upper side and back side of head right side, vital signs checked included , rate and rate and -check normal. Nursing progress note entered on (no timed) revealed that Resident #4 complained of pain on left side of back and stated it was from she had other day, stat x-ray ordered. Nursing progress note entered on at 6 PM by Manager revealed that Resident #4 placed on hourly check for a few days post a reported unwitnessed . Progress note on (no timed) revealed that Resident #4 ' s doctor was called Resident #4 was tired and , received doctor order of holding medications if was lower than 115, changed 10 mg to as needed and hold if sleepy/ tired, ordered laboratories and monitor three times a day. Progress note entered on at 1600 revealed that spoke to Resident #4 ' s doctor regarding concerns of Resident #4 ' s son and he stated that he will call Resident #4 ' s son. Progress note entered on at 4:30 PM revealed that spoke to Resident #4 ' s doctor regarding Resident #4 ' s critical lab results and ordered to send Resident #4 to the hospital and he will call Resident #4 ' s family. Progress note entered on / at 4:45 PM revealed that Resident #4 ' s doctor ordered to send Resident #4 to the emergency , family informed. Progress note entered on at 5:00 PM revealed that called Resident #4 ' s son to inform that Resident #4 was going to the hospital. Progress note entered on at 5:45 PM by Manager revealed that Resident #4 transported to hospital via nonemergency ambulance; resident was alert when she left, walked onto the transport bed.

Review of Resident #4 ' s record revealed that there was a doctor order received on for X-ray pelvis/left indicated due to /pain. There was a doctor order received on for labs drawn urinalysis culture and sensitivity, hold medicines if lower than 115 and rate 60, change to as needed and hold if tired/sleepy, monitor vitals three times daily for five days. There was a doctor order received on for X-ray back and head to rule out , pain. These three doctor orders were signed by Resident #4 ' s doctor.

Review of Resident #4 ' s medication administration records (MARs) revealed that doctor order for monitoring vitals three times daily for five days was transcribed as monitor and rate times daily for five days. It was scheduled at 9 AM, 3 PM and 5 PM starting on . Documentation on Resident #4 ' s MARs revealed that on nurse documented just , at 9 AM and

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3 PM.

In an interview on at 10:48 AM the LPN revealed that she called Resident #4's doctor but she did not document it. Resident #4 had a bump in the back of her head. LPN did the initial assessment after the suspected and check and passed the information to next shift nurse. She understood that there was no documentation of following the policy and procedures after a and facility changed it just after this incident. She realized at the time of interview that she did not transcribe in the right way the doctor order received to the MAR (medication administration record).

In an interview on at 11:22 AM the Administrator revealed the only check was the one in Resident #4 ' s record. Administrator acknowledged that Resident #4 ' s by facility's CNA and LPN. Administrator recalled that LPN stated that she was going to notify the doctor; Administrator did not recall following up. Administrator agreed that according to the documentation in record nurses did not follow the policy and procedures after a and facility changed it just after this incident. Administrator stated "We are on the process of revising the new policy but it has not been the committee".

Class III

**0030 Resident Care - Rights & Facility Procedures**

Based on observation, record review and interview, the Assisted Living Facility failed to obtain resident's consent to use of bed rails prior the use of it for two (#1 and #2) out of four sampled residents.

Findings included:

Observed on at 1:56 PM in # that there was a hospital bed with full bed rails and air mattress on Resident #2's .

Observed on / at 2:04 PM in # that there was a hospital bed with half bed rails and air mattress on Resident #1's .

Review of Resident #2's record revealed that there was a doctor order in record signed by hospice doctor on for full side rails. There was no resident's consent to the use of bed rail.

Review of Resident #1's record revealed that there was a doctor order in record signed by Resident #1's doctor on for half side rails. There was no resident's consent to the use of bed rail.

In an interview on / at 11:22 AM the Administrator revealed that there was no consent for the use

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of bed rails in record yet.

Class III

**Z814 Background Screening Clearinghouse**

Based on record review and interview, the Assisted Living Facility failed to register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic fingerprint submission to the Department of Law Enforcement.

Findings included:

Review of provider account information on Background Screening Clearinghouse revealed that facility has not registered none of its employees. Employee roster was empty.

In an interview on at 9:45 AM the Administrator revealed that Administrator thought that having background screening results were enough.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
East Ridge Retirement Village, Inc
19225 Sw 87th Ave
Miami, FL 33157
**RE: CCR #2016000380**

Dear Administrator:

This letter reports the findings of a complaint licensure survey that was conducted on 23, 2016 by representative(s) 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 , 2016.** 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 surveyor(s). Should you have any questions please call Sonia Bailey, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure 2016000380
XG90

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