STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910385	**03/06/2017**
NAME OF PROVIDER OR SUPPLIER **TROPICAL GARDEN VILLAS INC. (H**	STREET ADDRESS, CITY, STATE, ZIP CODE **432 SOUTH 'F' STREET** **LAKE WORTH, FL 33460**	

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

0000 - Initial Comments

A licensure complaint survey, #2016014416, was conducted on at Tropical Garden Villas (Home), License #5553, and completed on . The facility had deficiencies at the time of the investigation.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on resident record review and interviews, the facility failed to:
1) Contact resident's legal representative when resident exhibited a significant change (hospitalization) and was discharge from the facility to a skilled nursing facility; and
2) Maintain a written record of any significant changes/events that resulted in medical attention.
This affected 1 of 3 sampled residents (#1).

The findings include:

Resident #1 had been living at Tropical Garden Villas Assisted Living Facility since of 2012, with diagnoses which include and , and vision. Resident was alert and oriented x 3, and independent in all activities of daily living, except for self- , which she required supervision.

According to interviews with Facility Administrator and Facility Manager on at 10:50 AM, the resident had previously went to the hospital due to mild . She was discharged back to the facility with Home Health for physical and occupational , but the resident's insurance denied the before it could be provided. Resident #1 was sent back to the hospital due to on . On , Resident #1 was discharged to a skilled nursing facility for rehab services.

On at 11:11 AM, an interview was conducted with the brother of Resident #1. He stated, "My sister had a small and was sent to the hospital at the beginning of 2016. She was then sent back to the facility. I later get a call from [Nursing Home] stating they have my sister in rehab. I have no idea what is going on.
I contacted the Administrator of the ALF she lived in, and he didn't want to come clean when asked, 'Is my sister being thrown out or not?' I then spoke to [facility manager] and asked her the same question. She said, 'Yes, your [family member] told me [Resident #1] is all the time. I can't have her in here if she's all the time.'
I was upset because this [family member] is not [Resident #1's] Legal Care Giver, and [family member] only speaks with [Resident #1] once every 5 months. I speak to my sister every day. After 5 years, my sister [Resident #1] is thrown out? You just don't treat somebody like that. This has disrupted her life..."

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The brother confirmed he was not notified by the facility prior or at the time of his sister's transfer to a skilled nursing facility for rehab, or that the facility had determined to discharge the resident because they could meet her needs.

A review of Resident Progress notes, dated to , does not document any account of resident's "mild ," transfer to and return from hospital, , second transfer to hospital, and later transfer to rehab.
There is no documentation in the resident's record of any communication with Resident #1's brother or Social Worker at skilled nursing facility since her discharge to hospital on , or transfer to rehab on .
There is also no documentation of change in Resident #1's care needs which would prevent the facility from providing services to meet the Resident's needs.

On at 11:00 AM, a request was made to the Manager and Administrator regarding communication with Resident #1's brother, but no documentation was provided. The Administrator and Manager acknowledge the lack of required documentation within Resident #1's medical record.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on resident record review and interviews, the facility failed to provide a 45 day notice of discharge for 1 of 1 sampled residents whose needs the facility were unable to meet (#1).

The findings include:

Resident #1 had been living at Tropical Garden Villas Assisted Living Facility since of 2012, with diagnoses which include , and , , and , vision. Resident was alert and oriented x 3, and independent in all activities of daily living, except for self- , which she required supervision.

According to interviews with Facility Administrator and Facility Manager on at 10:50 AM, the resident had went to the hospital due to mild . She was discharged back to the facility with Home Health for physical and occupational , , but the resident's insurance denied the , before it could be provided. Resident #1 was sent back to the hospital due to on . On

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, Resident #1 was discharged to a skilled nursing facility for rehab services.

On at 10:10 AM, the Administrator confirmed Resident #1 did not have a bed hold during the time the resident was in rehab. During interview with the Administrator and Facility Manager on at 11:00 AM, they both stated that Resident #1 was not "discharged" from the facility because she had been expected to return to the facility, and "she would have been welcomed back once she got the services she needed."

During interview with the Social Worker at skilled nursing facility (SNF) on at 4:05 PM, she stated, "On , Resident came to [SNF] for rehab for .
On , I contacted the brother regarding potential discharge after completion of , . The brother stated the Resident had lived at [ALF] for 4 years. I then reached out to the Administrator of the ALF.
On , I reached out again to the Administrator. He was supposed to come to [SNF] on and assess the resident, as discharge was planned for . On , the Administrator did not show up.
On , I left a message with an ALF representative to have the Administrator contact me. I also left a message on the Administrator's cell phone.

On , I went to the facility. The Administrator nor the Manager were there, but I spoke with the Administrator by telephone. He requested I contact his wife. The number provided was not correct.
On at 3:37 PM, I received a call from the Administrator. The Administrator was notified the the Resident had met her rehab goals; she was ambulating well, and she was being provided a Transitional Care Nurse. A new copy of the resident's 1823 [Health Assessment] was provided to the Administrator. At this time, the Administrator stated he would not take the resident back because she was at increased risk for , and he did not have the staff to handle this." According to the Social Worker, neither the Administrator or his wife had any contact with the social worker after .

On at 11:11 AM, an interview was conducted with the brother of Resident #1. He stated, "My sister had a small and was sent to the hospital at the beginning of 2016. She was then sent back to the facility. I later get a call from [Nursing Home] stating they have my sister in rehab. I have no idea what is going on. I contacted the Administrator of the ALF she lived in, and he didn't want to come clean when asked, 'Is my sister being thrown out or not?' I then spoke to [Facility Manager] and asked her the same question. She said, 'Yes, your [family member] told me [Resident #1] is , all the time. I can't have her in here if she's , all the time.'
I was upset because this [family member] is not [Resident #1's] Legal Care Giver, and [family member]

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only speaks with [Resident #1] once every 5 months. I speak to my sister every day. After 5 years, my sister [Resident #1] is thrown out? You just don't treat somebody like that. This has disrupted her life..." The brother confirmed there was no 45 day discharge notice given to him, or Resident #1, which indicated in writing the reason why the resident was to be discharged.

A review of Resident #1's medical record provided no documentation of 45 day discharge notice provided to resident or legal representative at the time the facility determined it could not meet the resident's needs, nor was there documentation that Resident #1 was certified by a physician to require an emergency relocation to a facility providing a more skilled level of care requiring an immediate discharge.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record reviews and staff interviews, the facility failed to keep an accurate, up-to-date admission and discharge log for all of its residents, specific to Resident #1

The findings include:

A review of the Admission and Discharge Log shows Resident #1 as being a current resident at the facility. The Admission and Discharge Log had not been updated to reflect Resident #1's discharge to the hospital, and later to skilled nursing facility. If Resident #1 had a bed hold with the facility, discharge would not have been required, but on at 10:10 AM, the Administrator confirmed Resident #1 did not have a bed hold during the time the resident was in rehab.

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