STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968395	**05/22/2017**
NAME OF PROVIDER OR SUPPLIER **AVON MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **4531 SW 34TH DRIVE** **FORT LAUDERDALE, FL 33312**	

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

0000 - Initial Comments

AMENDED REPORT

An unannounced licensure complaint survey, CCR# 2017001240, was conducted on to , through at Avon Manor , License #12308 . 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 record review and interview, the facility failed to provide care and services appropriate to the needs of the residents and to contact the resident's health care provider and family in 1 of 3 (Resident #2) records reviewed. As evidenced by Resident #2 sustaining a at the facility, and not receiving medical attention or notifying the resident's primary care physician or responsible party until two days after the incident.

The findings included:

Resident #2 was admitted to the facility on with a diagnosis that includes some of the following: status post , compression ,wrist , and poor appetite. A review of Resident #2's record reveals an undated note signed by the administrator which reads as follows:On , 2016 at approximately 7:20 AM Resident #2 pulled away from her aide as she was walking her to the morning care. Resident to the floor, she was assessed by staff for and none were found. She said she was fine when asked. On , 2016 Resident #2 complained of some soreness and some developed on her arms. The facility doctor was contacted to determine if x-rays could be ordered. The facility doctor's office indicated that she was not a patient and could not order an x-ray for her.On , 2016 Resident #2 had difficulty ambulating and on arm worsened. 911 was dialed and resident to was taken to hospital. Hospital diagnosed a broken arm and admitted Resident #2. Resident's son was apprised of the incident.

Review of the incident report filed on reveals the following. On , 2016 at approximately 7:20 AM, Resident #2 pulled away from her aide and to the ground as she was walking her to the morning care. Resident #2 got up without aid and walked to the . Resident #2 was assessed by staff for at the time and none were found.The following day Resident #2 complained of soreness on her side and some developed on her arms. Physician that follows residents in the facility was contacted to request an x-ray. Since Resident #2 was not a patient of physician that follows the residents in the facility, mobile x-ray could not be ordered. Facility continued to monitor resident's condition. On , 2016, Resident #2 had difficulty

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ambulating and ˬ on her arm worsened. 911 was dialed and resident was taken to the hospital. Hospital diagnosed a broken arm and admitted Resident #2. Family member was contacted and apprised of incident.

A review of the emergency medical services ( ) report reveals that on at 2:03 PM, they were dispatched and arrived at the assisted living facility on at 2:07. arrived and met Resident #2, who was sitting in a wheelchair in the living , staff stated that she had 2 days prior and was exhibiting reduced mobility, ˬ, minor ˬ to residents left hand, left , and lack of desire to stand or ambulate.

A review of the hospital emergency (ER)dated reveals Resident #2 has a history of and and presents to the emergency , ˬ of a onset 3 days ago. Resident #2 lives in an ALF, and the administrator of the ALF is at bedside to report history. Administrator states that Resident #2 and could walk after but then was immobile the next day. Administrator also reports that resident has ˬ to her face due to hitting her head on something two weeks prior. Resident reports no pain. However, she is unable to straighten her left knee. Resident's report is limited due to mental status, resident is a poor historian. Further review of the ER report reveals that Resident #2 sustained an acute , endplate compression of T 2, and a left

In an interview conducted on at 9:07 AM with Resident #2's responsible party, they confirmed that they were not notified of the incident until Resident #2 was admitted to the facility on .

In an interview conducted on at 1:12 PM with the Administrator he states he was present on when Resident #2 , he assessed her, resident did not complain of pain. On he was present when resident complained of pain and we noticed some ˬ, contacted the facility doctor, who advised that it was not his patient and could not order x-rays. They monitored resident , and the soreness and ˬ got worse and on , they called 911 to take resident to the hospital. Resident could hardly get out of bed, and was diagnosed with a wrist and compression .

Class III

0123 - Fiscal - Resident Trust Funds - 429.27(3-4) FS; 58A-5.021(2) FAC

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Based on record review and interview, the facility failed to maintain a separate written accounting for each resident and co-mingled resident funds with facility funds for 3 of 3 (Residents #1,#2 and #3) resident record reviewed.

The findings included:

Resident #1 was admitted to the facility on with a diagnosis that includes some of the following: and a bloackage. A record review conducted on at 2:20 PM of Resident #1's filed revealed a notice dated from the Department of Children and Families indicatiing that she is entitled to recieve $198 per month as a personal needs allowance, futher review revealed that the administrator is the residents payee for her social security check.

Resident #2 was admitted to the facility on with a diagnosis that includes some of the following: status post compression ,wrist and poor appetite. A record review conducted on at 2:30 PM of Resident #2's filed revealed that the administrator is the residents payee for her social security check, but there was no further financial information contained in the file.

Resident #3 was admitted to the facility on with a diagnosis that includes some of the following: , major and . A record review conducted on at 2:40 PM of Resident #3's filed revealed a notice dated from the Department of Children and Families indicatiing that she is entitled to receive $198 per month as a personal needs allowance, futher review revealed that the administrator is the residents payee for her social security check.

In an interview conducted on at 2:46 PM with the administartor , he confirmed that he is the payee for all the residents in the facility, the personal needs allowance is co-mingled with the facility funds and he does not maintain separate accounting for resident funds for any of the residents in the facility.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the facility failed to ensure that each resident's file contained a copy of the residents contract with the facility in 1 of 3 (Resident #2) records reviewed.

The findings included:

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Resident #2 was admitted to the facility on . . . . . with a diagnosis that includes some of the following: status post , , compression ,wrist , , , and poor appetite. A record review conducted on . . . . at 2:30 PM, revealed that the file lacked a contract with the facility.

In an interview conducted on . . . . at 2:46 PM with the administrator, he confirmed the findings and stated that the resident has been at the facility since and still does not have a signed contract with the facility.

Class III