STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968395	**12/13/2017**
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

An unannounced licensure complaint survey, CCR#2017010509, was conducted on - at Avon Manor-, License #12308 . The allegation was substantiated. The facility had deficiencies at the time of the investigation.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to ensure that 1 of 5 residents' health assessments (AHCA form 1823 for Resident #3) was fully completed, to reflect Residents #3 current health status in regard to self-administration of medications.

The findings included:

Review of Resident #3's form 1823 dated revealed that he takes many medications and that he is . However, there was no indication that he is able to take his medications without assistance. Section B of the form was left blank. During an interview with Resident #3 at 12:20 PM, he however attested to the fact that he takes his own medication. He reported that he knows when to take all his medications. Resident #3 1823 however revealed that the resident is .

During an interview with the Administrator on , at 2:00 PM, he indicated that Resident #3 takes his medications by himself. However reported that he will have the health assessment updated.

Class III

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

Based on observation and interview, the facility failed to provide a safe and sanitary environment to five of five sampled residents (Resident #1, #2, #3, #4, & 5).

The findings included:

During an interview conducted with the Administrator on at 9:10 AM, he reported that he had five residents at the facility, three and two .

At 10:00 AM, after requesting to investigate the ' condition, this writer noted that the Administrator used a key to unlock # . Upon inquiring further of this situation, the Administrator reported that # is only for his staff, and guests which allocated only one

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all five residents. An observation of # revealed that it had no toilet paper dispenser , it was removed from the wall. Additionally, four sets of precut pieces of toilet paper were observed on top of the toilet tank. In addition, there was an uncovered trash bin observed next to the toilet bowl that contained toilet papers and other unidentified items.

During an interview with Resident #3, at about 1:00 PM, he said that when he moved in to the facility, he was informed that the residents often clogs the toilet bowl with toilet paper. As a result, he was given his own roll of toilet paper and wipes. He said that he uses the wipes and disposes of them in a trash bin placed in the . He said that he had no problem using the wipes, in fact, preferred them.

An interview with Resident #4 at 2:05 PM., revealed that she was not pleased with the way she was treated at the facility. She said that they give her pieces of paper to go to the . She was not giving her own roll of toilet paper.

A follow-up interview with the Administrator revealed that he is fully knowledgeable of the situation and that this procedure was implemented to prevent unnecessary clogging of the toilet, as he reported.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on observation, record review and interviews, the facility failed to ensure that 1 of 5 residents (Resident #5) was identified as an elopement risk.

The findings included:

On during review of Resident #5's health assessment, it was noted that the resident was at risk for elopement. This identification was indicated in section I of the form. The record also revealed that the resident was assessed on by her healthcare professional as having the following diagnoses: , and difficulty with ambulation. Observation conducted on that date at 1:00 PM revealed that Resident #5 did not have on her person any special method of identification.

During an interview with the Administrator on at around noon, he acknowledge that he did not put any identification on the resident's person and thereby confirmed the findings.

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Class III