STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968340	**03/09/2018**
NAME OF PROVIDER OR SUPPLIER **NURSING CARE BY ANGELS, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8085 S BABCOCK ST** **PALM BAY, FL 32909**	

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

0000 - Initial Comments

Complaint Investigation #2017014230 was conducted on , , , and . Nursing Care by Angels, License #12241, had deficiencies found at the time of the visit.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record review, observation and interview, the facility did not ensure 1 of 4 sampled residents met the minimum admission criteria upon admission to the facility and admitted a resident who was needed 24 hour nursing supervision and was needed total care with bathing and eating (#4).

Findings:

Resident #4 was admitted to the facility on and discharged on . A health assessment 1823 form, dated , listed diagnosis of , , high , and . Per the 1823 form, she needed total care with bathing and eating, assistance with all other activities of daily living, and medications. A hospice evaluation and treatment, dated , was ordered 8 months after admission.

On at 11:15 AM, the assistant administrator said the resident did not need total care.

Class III

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

Based on record review and interviews, the facility failed to seek immediate emergency care to 1 of 4 residents who sustained a and hit her head (#3), and failed to maintain a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services for 2 of 4 sampled residents (#1 & 2).

Findings:

1. Resident #3's health assessment 1823 form, dated , and an updated 1823 form, dated , listed diagnoses of , high , and . The report indicated that precautions/skin care precautions, were needed. The resident was alert and oriented to person and needed assistance with all activities of daily living (ADLs) and supervision with eating. An

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order for hospice evaluation was dated . Hospice face-to-face exam, dated , indicated the resident unable to stand on a scale without assistance due to and , immobility, and required assistance with all ADLs.

An incident report of indicated an incident date of at 4:20 AM. The resident's safety bed alarm sounded, and staff rushed to the bedside. The resident was noted on floor and said she got out of bed to look for a sock and . The son was notified. The resident was transported to the hospital on at 7 AM. The grandson was notified. Corrective action included to in-service staff when to call hospice/911, call 911 then hospice when a resident is on hospice services.

A facility note, dated at 4:39 AM, indicated the nurse received a call at 4:49 AM from the facility that the resident , reached the facility, and asked the resident what happened. The resident said she was looking for a sock and . The note reflected that by 4:55 AM, hospice was called and said they would send a nurse. The nurse told the hospice staff, "I said the resident was but stopped." The hospice nurse came at 6:30 AM. The hospice nurse said she had to call her supervisor and would let the staff know if 911 was to be called. At 7 AM, the hospice nurse askedstaff to call 911.

A hospice note, dated from 6:20 AM to 6:45 AM, reflected that there was an unscheduled visit because of with injury; "Resident was found on floor, from head. Resident had a 3 x 3 x .25 centimeter laceration/ to right forehead/scalp and obvious deformity to right wrist with . The to the forehead was cleansed and dressed. The resident was upset/crying. No -spine precautions per emergency medical service ( )."

The hospital record, dated , indicated the resident arrived by ambulance at 7:52 AM, and transferred to the hospital on at 11:53 AM. The resident's primary diagnosis was , secondary to through the anterior and , C1 arch. The examination notes indicated a right wrist mild deformity, and a right shoulder with small . The laceration to the forehead measured 2.5 centimeters and was repaired with four . The resident required critical care due to the acute , of vital with the increase probability (&) and high probability of imminent deterioration. Emergent interventions were taken to prevent life-threatening deterioration.

The medical center record indicated the resident was admitted on at 12:45 AM after being transferred from the local hospital to a higher level of care. She was transferred by ambulance and had a neck collar in place. The neurologist report indicated the resident had a ( ) and appeared there was at the facility about were she needed to go. The facility contacted the hospice who redirected the facility to the hospital. She went to the local hospital

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and was transferred for . The hospital scans of the neck indicated a Jefferson of the C1 spine. "A Jefferson is a bone of the anterior and , arches of the C1 , though it may also appear as a three- or two-part ." (wikipedia.org). She was to wear the neck collar for 3-4 weeks and then return for re-evaluation. She was transferred to a skilled nursing facility on .

On at 2 PM, the assistant administrator said the staff called the family 3 times and left a message but there was no reply. She received a call from the resident's grandson, who inquired about her financial information. During the conversation, he acknowledge that he knew the resident had a . The assistant administrator said, "I do not know anything about the resident." She added the resident had a bed alarm, floor mat and one alarm on her person. About 2 to 3 weeks after that conversation, the grandson came to pick up the resident's belongings except for the TV. She said staff A, who covered for her while she was out of the country, wrote the note, dated .

On at 12:30 PM, staff A said she covered for the owner/assistant administrator on . The staff called her at about 4:40 AM to 5 AM and told her the resident . She said she went to the facility, found the resident in bed. She said the resident complained of pain but she always complained of pain. She was able to state her name and the date. She said the resident looking for socks. She said the resident would forget that she was unable to walk. Her extremities did not look deformed. She called hospice. The hospice nurse arrived to the facility between 6:45-7 AM. The hospice nurse asked for all the details of the , called her supervisorand, and then called 911 because of the on the resident's head. She also called the resident's grandson, bur could not leave a message because the mailbox was full. The ambulance came about 7:30 AM. She added that whenever a hospice resident was ill or had , hospice was called. If the resident was not on hospice care, the family and 911 were called. She said, "It is my understanding to call hospice first because the resident has a ."

On at 11:15 AM, the assistant administrator stated she was not aware of what happened to the resident after the .

2. Resident #1 had a health assessment dated that listed diagnoses that included of . The healthcare provider's order, dated , indicated urinalysis with culture and sensitivity (C&S). The order, dated , indicated urinalysis C&S. There was no written documentation that indicated the change in health the resident experienced that needed a urinalysis and C&S. There was no evidence the significant party was informed of the change.

On at 1 PM, the administrator/Registered Nurse said the resident had foul smelling , called the family, but did not write it down.

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3. Resident #2 had healthcare provider's order, dated , that indicated urinalysis with C&S, and , an , 500 milligrams twice a day for 14 days. There was no documentation that indicated the change in health the resident experienced that needed a urinalysis and C&S. There was no evidence the significant party was informed of the change.

On at 1 PM, the administrator/Registered Nurse said, "I called family about , but did not write notes about it"

Class II

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on interview and record review, the facility failed to submit the Comprehensive Emergency Management Plan (CEMP) to the local emergency management annually for review and approval.

Findings:

A Fax from the facility on at 7:30 PM revealed a letter from the Brevard County Office of Emergency Management which indicated the office had received the facility's CEMP. It read, "Plan was delivered to our office in 2017." The letter had the county stamp and was dated . The letter also read, "Due to hurricane Irma our office has been back logged." The last letter of approval for the CEMP was dated .

Hurricane Irma passed through the state in 2017.

On at 10 AM, the assistant administrator said she unable to recall when she sent the CEMP for county review.

Class III