STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968935	R 09/11/2018
NAME OF PROVIDER OR SUPPLIER **EAST RIDGE RETIREMENT VILLAGE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **19225 SW 87TH AVE** **MIAMI, FL 33157**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

A Complaint Revisit Survey was conducted on 09/10/2018-10/05/2018. East Ridge Retirement Village, Inc. with an extended congregate care component, license number 12771, had the following deficiencies identified at the time of survey:

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, interview, and record review, the facility failed to ensure that 1of 106 sampled residents met the criteria for continued residency (Resident #69).

Findings included:

1) On at 5:36 AM, observed Resident #69 in bed with his wife. He complained of feeling uncomfortable.

On at 5:36 AM Staff S stated Resident #69 was from the memory care unit.

A review of Resident #69's file showed the resident was admitted on , the health assessment dated , showed medical history and diagnoses: , high , chronic kidney III, status post , , skin , status post replacements. Physical or sensory limitations: or behavioral status: mild , Occasional disorientation, memory loss. Nursing/Treatment/ , Service Requirements: Medication administration. Special Precautions: . Per health assessment the resident was not an elopement risk. The resident was independent with ambulation and eating, needed supervision with bathing, dressing, self-care ( ), and toileting. The resident needed assistance with transferring. The resident needed medication administration.

A review of Resident #69's wander data collection tool documented evaluation factors: Is the resident , with poor decisions-making skills (i.e. poor decisions, cues, intermittent , inattention, disorganized thinking)? Documented Yes. Does the resident ambulate independently, with or without the use of assistive devices (include wheelchair)? Documented Yes. Does the resident ambulate independently, with or without the use of assistive devices (include wheelchair)? Yes. Is the resident seeking to find spouse/family? Yes. Summary of Findings: Resident is , has diagnosis of . Functional Assessment dated documented requires regular prompting due to and disorientation. Wanders intrusively but can be redirected.

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A review of Resident #69's file showed nurse's noted dated documented:
- Resident wandering halls not listening to instructions redirecting to went out because resident would not let her rest. Redirected to , resident stable. At 12:40 PM, Resident walking in hallway, stopped and argued with another resident was seen by 2 private aides that said he hit her asked other resident she said yes will let supervisor and family know.
- ~ Resident wandered halls going into other resident's called daughter she said he is supposed to be in memory as of this afternoon told supervisor, he is to be transferred today. 2:35 PM Resident transferred to memory unit all meds and report given to nurse accompanied by his wife stable.
- Resident arrived to unit at 1443 this nurse went to resident's obtain vital signs and skin observation. Resident laying in bed and wife by his side. Resident alert to name only. Resident frequently asking to go home and about his wife. Stated "I do not want to be kidnapped. I want to be with my wife."
- Resident observed ambulating with walker throughout unit and asking for his wife. Resident also noted crying and asking for his wife.
- Resident observed walking around looking for his wife, crying intermittently, and saying "I want my wife" she is ."
- Resident , , resisted and physically aggressive. At 2:15 PM power of attorney visited unit and took resident out to lunch. Power of attorney returned and conveyed concerns about multiple discolorations to resident's arms. Power of attorney asked if staff would call her when there's resistance or difficulty getting resident cooperate and whatever activity that's causing him to be agitated or uncomfortable. At 7:30 PM Resident's wife upset and crying saying that can't leave her husband in memory and go back to her ALF 2nd floor. Suggested that wife could stay in resident's memory.
- Resident walked over to memory unit. Medication administered and resident walked back to 2nd to assisted living facility.

On at 11:09 AM the memory care nurse stated that she was not aware about Resident #69 being transferred to the assisted living side for the night and that the staff did not inform her of the change. She further said the resident was placed in the memory care unit around , , because he was wondering the halls and he was becoming disoriented.

On at 11:15 AM assisted living nurse stated Resident #69 was from the memory care unit but he was asking to see his wife and the wife did not want to separate from him. The resident was crying for his wife so his power of attorney requested that they allow the resident to sleep with his wife on the assisted living side.

2) A review of Resident #46's health Assessment dated , showed Medical history and

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diagnoses: OBS (organic) mild , , Atherosclerotic , history of hyperemia. Physical and Sensory limitations: poor memory. or behavioral status: Poor memory. Nursing/treatment/ service requirements: activity of daily living supervision. Special Precautions: Precaution. Per health assessment the resident is an elopement risk. The resident is independent with ambulation, eating, and transferring, needs supervision with bathing, dressing, self-care ( ), and toileting. The resident needs medication and will continue to monitor.

A review of Resident #46's Nurses notes documented:
- at 8:00 PM-Resident found wandering in the village by the back gate. Resident escorted back to her apartment by security officer. As per nurse supervisor states to take resident to memory care for the weekend due to wandering. Resident transferred to memory care at 7:30 PM by staff. Gave report to memory care nurse.
- at 1:10 PM Resident dancing in activities, As per nurse assistant, resident 1211 walked up to another resident and started dancing in front of other resident. Other resident asked her to stop. 1211 continued to dance, then other resident kicked her in the leg twice. No , noted, resident alert, Ox 1, 0 signs of pain, 0 signs of distress. Daughter notified and made aware.
- - Resident walked out of the building in the rain, when tried to redirect her by staff she got very upset. Resident was picked up by security. Family member in resident apartment stated they are the one that told the resident it's ok to go for a walk on the sidewalk. I tried to explain to family member about her safety. She said resident is able to return to her apartment.
- at 8:00 PM-Resident found wandering in the village by the back gate. Resident escorted back to her apartment by security officer. As per nurse supervisor states to take resident to memory care for the weekend due to wandering. Resident transferred to memory care at 7:30 PM by staff. Gave report to memory care nurse. Power of attorney notified via voice mail.
- 12:00 AM Resident arrived to unit around 19:30 accompanied by nurse and nurse assistant. Stated in report resident to be transferred to this unit for respite care for the weekend. Resident sitting on chair at the time watching TV. Resident ambulated throughout unit constantly asking for husband and babies. Resident agitated as night progressed, stated "I am going to set this place on fire." Resident kicked the glass door. Seeked exit multiple times. Walked in to nurse office I hit the counter a couple times asking "why did you do this to me? This nurse explained to this resident multiple times about her stay in the unit. Agitation increased this nurse asked resident what was going on and she requested not to be touched or she would kill people. Nurse assistant and this nurse observed resident pulling curtain in hallway. This nurse was on her way to # , resident following at distance this nurse went in closed the door.
- at 12:45 AM 0.25 MG pulled and administered by mouth by doctor offered resident water in which she slapped cut off his hand. Resident ripped wall art on the hallway walls stating "She was going to kill that [ ] who out her here and took her house key" attempt to bring resident teddy bears

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from her apartment in the ALF to her memory and redirecting from doctor, officer and nurse assistant was unsuccessful for calming resident down. Doctor made decision at this time to send resident via ambulance of she would go voluntary to hospital for crisis care if involuntary to resident by officers.

3) On at 5:38 AM observed in Resident #67 in bed, there was a bottle of 0.4 MG on the table side. According to the National Library of Medicine, this medication is a , used to treat episodes of (chest pain) in people who have by relaxing the so the does not need to work as hard and therefore does not need as much .

A review of Resident #67's health assessment dated showed the resident was and required medication administration. There was no documentation that the resident was under hospice care.

On at around 4:30 pm, the facility's Medical Director was interviewed regarding the resident's ability to self administer the in light of her . He stated that he had completed the assessment of Resident #67's need for medication administration, but he was not closely familiar with the resident's medical history. The Administrator, interviewed separately by telephone, stated that Resident #67 was under continuous hospice care and the registered nurse at her bedside was responsible for administering the medication. Observation on at 5:38 am showed that no nurse was present. Requested documentation of the hospice services was not provided.

Uncorrected

Class III

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

Based on observation, record review, and interview, the facility failed to provide the appropriate care and services to the residents. The facility failed to prevent continuous for five out of 106 sampled residents (Residents # 5,17,18,30,32).

Findings included:

A review of Resident #5's file showed the resident was admitted on , the health assessment dated . Medical history and diagnoses: , high , , , gait imbalance, left foot deformity. Physical or sensory limitations: gait imbalance. or behavioral

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status: , . Nursing/treatment/ , , service requirements: Medication administration. Special precautions: . Per health assessment the resident is not an elopement risk. The resident needed supervision with ambulation, needed assistance with bathing, dressing, self-care ( ), toileting, and transferring. needed medication administration.

A review of Resident #5 file showed nurse's notes dated at 10:30 PM documented: A reported to left , leg. Resident was in bed on her back. Skin discoloration noted to open area. Resident unable to recall what happen. Area cleaned with NSS (Normal Solution). Dressing applied, no complaint of pain at this time.

Review of Resident #17's record showed that admission date was on . The health assessment completed on . It had medical history and diagnoses of and muscle . She was risk and deficiency with precautions. The resident was independent and needed supervision with eating, needed assistance with ambulation, bathing, dressing, self-care, toileting, and transferring.

Reviewed of nurse's note showed that on the activity person approached to nursing and informed that someone was on the floor. The LPN (licensed practical nurse) went to the small dining , the resident was sitting on the floor. Activity person said that the resident was asleep and off the chair. The resident had a to top of right hand outer side with slight amount of .

On the resident out of chair during activities, the resident found lying on the left side on the floor. The resident had a to left side of head above area ( ) and left elbow. It was controlled when pressure was applied. According to the activity person the resident out while sitting.

On at 1:02 AM, one of the CNA (certified nursing assistant) called the night nurse to the memory unit and the resident was found sitting in the floor. On the resident had purple skin discoloration area to left calf that measured about 3 cm x 3 cm. POA (power of attorney)and MD notified. On the skin was pink and warm. On at 2310 the resident had red/ purple discoloration area to right upper arm. MD and POA notified.

On at 2:34 PM, the memory care unit manager revealed that facility staff do weekly skin check. Her skin discoloration was old according to the nurse. Her daughter took her out and she came back with the discoloration. They signed when they go out in pass.

A review of Resident #18's file showed the resident was admitted on , the health assessment

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dated showed medical history and diagnoses: ( ), . Physical or Sensory Limitations: uses walker. or behavioral Status: AAO (alert and oriented) x 3. Nursing/Treatment/ Service Requirements: none. Special precautions: . Per health assessment the resident is not an elopement risk. The resident needed supervision with ambulation, dressing, self-care ( ), toileting, transferring. The resident needed assistance with bathing, and is independent with eating. The resident needed medication administration.

A review of Resident #18's file showed nurse's noted dated documented at around 10:55 PM resident found sitting on floor head resting against bed. Resident #18 stated "I in the crawled to the ." No visible injury or discoloration noted at this time. Resident able to move upper and lower extremities no limitation, no pain at this time. Resident picked up off the floor with assistance x 1 and put to sit on bed and made comfortable.

A review of Resident #30's file showed the resident was admitted on , the health assessment dated , showed Medical history and diagnoses: , incontinence, , unstable gait. Physical or sensory limitations: gait imbalance- walker. or behavioral status: Not oriented to date, time or place. Nursing/treatment/ service requirements: Routine medications. Special Precautions: . Per health assessment the resident is not an elopement risk. The resident needed supervision with ambulation, dressing, eating, self-care ( ), the resident needed ambulation with bathing, toileting, and transferring. The resident needed medication administration.

A review of Resident #30's file showed nurse's noted dated documented: Resident found by 2 nursing assistants upon doing rounds on the floor between her bed and the wall. Resident quickly observed with redness and some to her forehead and bridge of nose. Resident transferred back to bed x 2 assist. Resident cried out complaint of pain to back, shoulders and hips. 911 was called three medics arrived at 7:10 transferred to hospital for evaluation. Called and spoke to resident's son and notified of the event. The resident left via ambulance to hospital.

A review of Resident #32's file showed the resident was admitted on , the health assessment dated showed, medical history and diagnoses: Parkinson's , Right femur , right hip , and history of pelvic . Physical or Sensory Limitations: Ambulates with walker and or behavioral status: Alert and forgetful at time. Special Precautions: . Per health assessment the resident is not an elopement risk. The resident needed assistance with ambulation, bathing, toileting, and transferring. The resident needed supervision with dressing and self-care ( ), and is independent with eating. The resident needs assistance with self-administration.

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A review of Resident #32's file showed the facility's internal incident report stating that Resident 32 on at 1:19 (no indication of AM or PM) stated "I was standing up from the wheelchair to readjust myself and the wheelchair was not locked and I slipped." Resident found lying on the left elbow. Resident lying and left elbow on left side, wheelchair near resident, redness noted to left side of head near temple area. Pillows from wheelchair noted on the floor. Further review showed:
On at 10:40 PM nurse assistant reported found Resident #32 on the floor. Observed in the living her left side. at 5:15 PM, Resident found sitting on , next to wheelchair in living , nurse assistant. Resident found sitting on , next to wheelchair in living , nurse assistant. Resident stated "I was trying to pick something off the floor and lost my balance."
at 11:30 AM, Resident states "I was leaving over in my wheelchair trying to pick up my photo book when I slid from my wheelchair to the floor.
at 3:05 PM Resident stated "I was brushing my , I slid down on the floor." Nurse assistant reported she found resident on the floor. Observed on the on her left side, floor wass wet.
at 4:03 PM 1203 Resident #32 pushed pendant and I went to check on her. Upon arrival at 1203 I found Resident #32 on the floor in her living . I notified the nurse on duty. The nurse and I assisted Resident #32 off the floor back in her wheelchair.
On at 7:35 PM Resident #32 stated "I went around to get my medication. My leg give away, I ." Nurse assistant reported she found the resident on the floor on her left side in the kitchen.

Uncorrected

Class III

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

Based on observation, record review and interview the facility failed to honor resident's right to be free of physical for one of 106 sampled residents (Resident #83).

Findings included:

On at 5:23 AM observed in # Resident #83 was in bed with full bed rails attached to her bed.

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On at 5:25 AM Staff S stated "Resident #83 is not a hospice resident."

On at 5:40 AM observed in # Resident #105 with a Private Aide, and observed chairs used to restrain the resident by the bed.

On at 5:42 AM Private aide stated this was done to keep her secure in the bed.

On at 3:35 PM the Administrator stated that the persons that were placing the chairs and the full bed rails were the private and it this practice was not notified to the assisted living staff.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and record review, the facility failed to keep medications secured at all times.

Findings included:

On at 5:38 AM observed in Resident #67 in bed, there was a bottle of 0.4 MG on the table side.

A review of Resident #67's health assessment dated showed the resident was and required medication administration.

Class III

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

Based on interview and record review, the facility failed to have an admission and discharge log.

Findings included:

On at 5:48 AM, Staff E revealed that the resident from expired.

Review of Resident #106's record showed that admission date was . The last progress notes showed that on the resident complained about in right arm. Resident sent to the hospital.

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Review of resident and facility records did not show when the resident was discharged and the reason for discharge.

On at 1:42 PM, the Administrator stated the case manager or transition nurse visited resident at the hospital and followed up about their status. She further stated that she finds out if the resident will be back or not to the facility, and that the facility holds the bed until they know if the resident will return. At 1:51 PM, the Administrator revealed that the admission and discharge would not say the reason the resident was discharged. A resident was not discharged when hospitalized.

Class III

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

Based on record review and interview, facility failed to have complete health assessment for three out of 106 sampled residents (#8, #17 and #27).

Findings included:

Review of Resident #8's record showed that admission date was on . The last progress note in the record was on . There was a note on the resident was unresponsive. The facility called emergency service and the resident went to the hospital. There was no documentation about discharge date.

On at 12:11 PM, the Assisted Living Facility's supervisor revealed that Resident #8 went to the hospital and from there was transferred to the health center. She did not recall when that happened. The facility did not document when the resident wasnot at the facility.

Review of Resident #17's record showed that admission date was . The health assessment completed on showed the height section was blank and that the resident had medical history and diagnoses of and muscle . It showed that she was independent and needed supervision with eating. There was a note that the resident did not take any prescribed medication. It showed that she needed medication administration. The section that indicated if she needed help taking her medication was blank.

On at 2:34 PM, the Memory Unit Manager revealed that height section was not completed. She also stated the resident does not need help with medications because she does not have medicines to

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be given.
Review of Resident #27's record showed that the health assessment was completed on . . . . . The question of whether the resident needed help taking her medication was blank. The boxes indicating whether the resident needed assistance with self-administration of medication or needed medication administration were also blank.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview, the facility failed to submit an adverse incident report within one business day after the incident to AHCA for one out of one hundred and four sampled residents (Resident #45).

Findings included:

Review of Resident #45's record showed that the admission date was on . . . . . Health assessment completed on . . . . . It showed medical history and diagnoses of advanced . . . . . hearing loss, ... Resident was . . precautions. Resident needed supervision for ambulation, eating, and transferring, and assistance for bathing, dressing, self-care and toileting. The resident had a . . . . . It was inserted on . . . . . The resident had excessive uncountable . . . . from . . . . . on . . . . . Resident sent to hospital.

Resident #45's Health assessment completed on . . . . . It showed medical history and diagnoses of . . . . retention, ... hypertrophy, ... , ASVD. Resident was . . precautions. Resident was independent for ambulation, eating, and transferring, and supervision for bathing, dressing, self-care and toileting.

Review of progress notes showed that on . . . . . the doctor was notified that resident had sign and symptoms of frequent voiding, urinalysis done with culture and sensitive. On . . . . . , the doctor order to insert a . . . . . and started . . . . . insertion was attempted 3 times but the resident complained of pain. Doctor was called and order to send the resident out to the hospital. On . . . . . , the resident returned to the facility with a 16Fr . . . . . with 100 ml of pinkish red color . . . ; it was patent. On . . . . . at 12:30 PM, the resident aide answered to call from apartment. At arrival, found 3 CNAs (Certified Nursing Assistant) in the apartment, the resident sat in the toilet in the . . . . . all over his . . . . , toilet, floor, and surrounding areas. Excessive uncontrolled . . . . . noted to . . . . of penis. . . . . noted to have been pulled completed out. . . . . clots

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of large sizes noted in toilet and on . Resident's 1on1 CNA stated she was in the living she heard a noise; she then observed resident walked into attempt to pee in toilet. At that point the aide observed a lot of to resident's area and running to legs. The aide stated that she sat him in the toilet to call for help.

Review of Resident #45's hospital record showed that the resident went on to the hospital with chief complaint of retention.

On at 12:07 PM, the Assisted Living Facility's supervisor revealed that the resident had retention and the doctor ordered for . The doctor sent him out to the hospital for placement of the . The resident returned to facility with a from the hospital. The ALF supervisor was informed in the morning that the resident was sent out the night before because he from the . The resident did not return to the ALF; he was in the health center. The ALF supervisor was not sure that the resident was in the health center. He did not have any issues with from his penis before.

On at 12:16 PM, the administrator revealed that facility did not complete the adverse incident because it was a medical condition, nothing that the facility could prevent.

On at 2:44 PM, the ALF supervisor revealed that the date of the incident with Resident #45 he was with an aide from the facility and she was new. At 2:49 stated, "can I see the incident report? I am hearing he has a private duty at that time." That person was not our staff she was private duty. Facility's nurses will be providing . She was not our staff, she came from the family. The family wanted to have someone with him. The facility had nurses and CNAs working in the floor. The family decided to put the private aide to avoid this."

Uncorrected

Class III