| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11968935 | R<br>05/22/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **EAST RIDGE RETIREMENT VILLAGE, INC** | **19225 SW 87TH AVE MIAMI, FL 33157** |

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

**0000 - Initial Comments**

A revisit to a six month monitoring survey was conducted at East Ridge Retirement Village , Inc. on through . Deficiencies were found at the time of the inspection.

**0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27**

Based on observation, record review and interview, the Assisted Living Facility (ALF) failed to respect the residents' rights to receive medical care for two out of 16 sampled residents (#15 and #16).

Findings included:

On at 10:33 AM, observed a sign outside of Resident #15's room that stated instructions on how to help the resident ambulate due to a , related to a she had 2 months ago.

On at 10:33 AM, the ALF Manager revealed that they wanted to send the resident to the hospital; however, the resident's daughter refused to have her sent to the hospital. She was seen by the facility's Primary Care Physician (PCP) and received , , , , , and reassessments.

A review of the adverse incident report filed on showed that on at approximately 5:50 AM, one of the Certified Nursing Assistants (CNA) found Resident #15 on the carpeted floor by the of the bed in sitting position. On at approximately 9:00 AM, the resident complained of , to her right arm and , medication was administered. On at approximately 9:00 AM, the resident complained of , to right . She then received , medication. She had an , completed on at approximately 7:30 PM of the right , right , and right . The , results were negative. She complained of , on twice. On , she did not eat much. On at 830 AM, the resident complained of , when she attempted to get out of bed and , medication was administered and she was left in her bed. At 9:00 AM, she complained of , to the left , . The PCP ordered to have the resident sent to the hospital for further evaluation if the Power of Attorney (POA) agreed, if not, then have an , to left, right , and , at the facility. On at 11:00 AM, the POA was in the facility. The POA did not want the resident to be sent to the hospital and requested to have the , be done at the facility. The , was completed on at 2:30 PM. On , after the facility called the , company for the results, they faxed the , results to the facility on at 1215 PM. The PCP was informed about the x-ray results of a positive to the right , pubic laterally and the right pubic medially with evidence of , . At 1230 PM, the PCP stated this was a , resident with , and her daughter did not want to transfer the resident to hospital. The POA was notified about the x-rays results

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and would speak with the PCP about the options available. When the daughter was at the facility, she stated that did not want her mother to be sent to hospital because the care in the ALF was good and they can keep her comfortable. It also showed that the resident's daughter refused the [illegible] that was recommended.

Further review of the resident record showed there was a living will completed on [illegible] for Resident #15. It showed that the resident's dying would not be [illegible] prolonged if she was [illegible] and had a [illegible] condition, an [illegible] condition, or was in a persistent vegetative state. It did not specify that the resident wished to be denied any type of medical treatment.

Review of the adverse incident report filed on [illegible] showed that on [illegible] at approximately 7:20 AM, one of the CNAs' called the nurse on shift to go to Resident #16's room. The nurse entered the room and found the resident lying on his left side on the carpet floor near the bathroom. He expressed discomfort to the right [illegible]. The hospice nurse and doctor were informed and the doctor gave orders for [illegible] to the right [illegible] and left [illegible]. On [illegible] during the [illegible] pm shift, [illegible] was completed. On [illegible] at approximately 9:50 AM, results were faxed to the facility showing a positive acute [illegible] of the [illegible]. The hospice nurse and the POA were notified. His family stated they did not want anything to be done, just to keep him comfortable.

On [illegible] at 12:43 PM, the ALF Manager revealed that the resident's family did not want to get a hospital bed.

Class III