STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910733	05/06/2019
NAME OF PROVIDER OR SUPPLIER **VIP CARE PAVILION LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **6810 SW 7TH STREET** **MARGATE, FL 33068**	

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

0000 - Initial Comments

A complaint investigation (complaint # 2019001925) was conducted at VIP Care Pavilion, LLC, License # 4783 on . 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 observation, interview and record review, the facility failed to contact the resident's family when the resident was discharged to the hospital. The facility also failed to maintain a written record, updated as needed of any significant change that resulted in medical attention, for 1 of 3 sampled residents, (Specifically, Resident # 3).

The findings included:

On at 10:15 AM, an observation was made of a female resident sitting in the Section II activity area. The resident was observed with a purple colored over her right . An interview was attempted with the resident. She smiled and nodded to the questions asked about the incident causing the injury to her . She was deemed uninterviewable due to her cognition level.

A review of the Florida Health Assessment form (AHCA 1823 form) for Resident # 3 dated was conducted. It reveals the following diagnosis of degenerative of the nervous system, physical or sensory limitation to be assessed, alert and oriented with periods of . Nursing/treatment/ , service requirements to be defined. She is not coded as a -risk.

On at 03:00 PM, an interview was conducted with the Power of Attorney (POA) for Resident # 3. The POA was seen in the Nurses station asking the RCD about the that his mother experienced on . He says he has gotten 3 different reports. He stated that the staff did not call him until 3.5 hours later after the incident occurred. He says they did not send her out to the Emergency Room. He stated he came into the facility because the Administration failed to acknowledge his complaint. He says that he heard they could not stop the .

On at 03:40 PM, An interview was conducted with the Medication Tech (Med Tech) says she found the resident on the floor at 9:25 PM. She says Resident # 3 was not nor . She says the resident was not complaining of , . She stated she was fine. She says she put water and , on the resident, and called hospice immediately. She stated the Nurse was called at 9:30 PM. She says she continued to watch her during this time. She says Resident # 3 needs total care with all Activities of Daily Living (ADL'S), except assistance with eating. She can make her needs known

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for only something to drink. She says she has an alarm on her bed, and recliner, but not on the wheelchair.

A review of the Incident report reveals the following. The incident occurred . . . . . Saturday night. Section II at 9:27 PM, in the resident's room. The Medication Technician, Supervisor. Patient got up from chair and . . Unwitnessed. Resident Care Director notified first. Hospice notified, advised runner (nurse) would be sent out. Primary Care Physician notified. The Nurse came at 11:00 PM. The facility failed to contact the family immediately. Nursing note missing from file regarding the event. No mention or details of the mentioned in the nursing notes. There were no physician orders in file. There were no physician notes in the file.

On . . . . . at 03:30 PM, an interview was conducted with the Staff that was present during the time period of the incident concerning Resident # 3. The Med Tech Supervisor stated he was told that the Certified Nursing Assistant (CNA), found Resident # 3 on the floor. He says she called hospice. He says around 11:00 PM, the hospice nurse came to the facility. The CNA provided ice, but he did not see any . . . . He says there was a conflicting report stating the resident slipped out of the chair. He says he printed out the Medication Observation Report (MOR), the ( ) for the transportation. He says hospice is always responsible for contacting the physician and the family.

On . . . . . at 04:00 PM, an interview was conducted with the Administrator and the Administrative Staff. They acknowledged the findings.

Class III

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

Based on observation, interview and record review, the facility failed to display the telephone number for the licensing agency: Agency for Healthcare Administration, (AHCA). This poster provides the phone number for lodging complaints, and was not posted in full view in a common area accessible to all residents. The facility also failed to demonstrate that the grievance policy and procedure is implemented upon receipt of the complaints for 1 of 3 sampled residents reviewed (Resident # 3).

The findings included:

On . . . . . at 10:00 AM, a tour of the facility was conducted. It was revealed that the AHCA poster, which displays the telephone for lodging complaints was not displayed in the facility.

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On at 10:25 AM, an interview was conducted with the Regional Director. She was asked to provide the copy of the facility grievance policy. She was unable to produce the internal policy. She stated tha they record the (complaints, issues, concerns and problems) in the log and the log is maintained by the Administrator. The Administrator is responsible for conveying the outcome to the complainant.

On at 10:30 AM, a review of the facility grievance log revealed that there was only one (1) complaint logged for the month of , in the entire log book.

On at 03:00 PM, an interview was conducted with the Power of Attorney (POA) for Resident # 3. The POA was seen in the Nurses station asking the RCD about the that his mother experienced on . He says he has gotten 3 different reports. He stated that the staff did not call him until 3.5 hours later after the incident occurred. He says they did not send her out to the Emergency Room. He stated he came into the facility because the Administration failed to acknowledged his complaint. He says that he heard they couldn't stop the .

On at 04:00 PM, an interview was conducted with the Administrator and the Administrative Staff. The Business Office Manager conducted the facility tour and confirmed the findings. They also acknowledged the findings that the grievance log may not have been maintained properly.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on interview and record review, the facility failed to follow physician orders, for 2 of 3 sampled residents reviewed (Resident # 1 and # 2).

The findings included:

A review of the resident's medical chart revealed the resident was admitted into the facility around . A review of the Florida Health Assessment form (form 1823) was conducted. The form was complete on . It revealed that the resident was initially admitted with the following diagnosis: , and His or behavioral status: , agitated, resistance to care at times. He Is independent with eating, ambulation, and transferring. He requires supervision with the following: bathing, grooming, self-care grooming, and

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toileting.

On a review of the Physician Orders dated state - protocol with . Apply 5% Cream to entire body from down and leave on body for 12 hours. Wash all bedding and clothes in hot water the next morning. Repeat entire procedure in a week. Apply Triacinolone cream to irritated areas as needed twice daily. Give 15 mg tablet at the same time as the Premehtrin cream. A review of the physician order reveals that the Consult and Hospice Consult was ordered along with the Hydroxczine 12.5 mg by twice x 10 days on .

A review of the physician order dated for a Dermatologist consult was conducted. It was ordered by the Primary Care Physician of the facility.

A review of the progress notes dated were entered by the Primary Care Physician (PCP). States a male with hearing loss and . Has a erythrmalous maculopapular has not improved with treatments with multiple creams including and bethamethasine clotmazole or to reduce itching. Has not seen Dermatologist.

On at 11:30 AM, an interview was conducted with Staff A. She stated Resident # 1 was a little . He ambulates alone. She says she noticed he had a on his body. She says he had visitors and they never complained. She says he needed help . She says he would scratch. She says she would apply cream, but it didn't help. She says he was sent to the hospital.

A review of the Patient Discharge Summary dated reveals the resident had the following conditions when he was discharged from the hospital: , medication, , and prevention.

On at 01:30 PM, an interview was conducted with the Resident Care Director. She was advised the (Derm)Consult could not be located. She conducted a side-by-side review of the record for Resident # 1. She could not locate the consult that was ordered by the Primary Care Physician (PCP) on . She could not locate any notes regarding the Derm Consult for this period of - .

A review of the medical chart for Resident # 2 was conducted. It revealed that the 1823 form dated has the following diagnosis: , , , , Hashinoto . Physical or Sensory Limitations: Unsteady Gait, Encourage Walker, wheelchair. or Behavior Status - , Agitated, assistance to care at times. She requires supervision with ambulation, self care

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grooming, transferring. She requires assistance with bathing, eating and toileting

A review of the nurses notes dated shows the patient (, .) was seen by the PCP, and the physician is aware of foul smelling at 10:23 AM. Order for Labs, , Analysis, (UA), White Count (WC), Cypro 500 mg, by twice a day x 5 days. aware and fighting. Appetite varies, sleeps well. Patient in wheelchair, per transport. Daughter visits and aware of plan of care. (current).

A review of the lab reports show the last visit for the Clinical Lab report was 11/14/2018. There were no new lab orders found.

On at 02:50 PM, an interview was conducted with the Resident Care Director (RCD). She acknowledged the findings that the staff did not document the onset date of the signs and symptoms of the , ( ) in the nurses notes or follow-up on the lab orders.

On at 04:00 PM, an interview was conducted with the Administrator, Resident Care Director and the Regional Director. They acknowledged the findings that the Physician Orders for the consult and the Laboratory orders were not completed.

Class III