STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968537	06/18/2019
NAME OF PROVIDER OR SUPPLIER **ELITE MANOR-KISSIMMEE**	STREET ADDRESS, CITY, STATE, ZIP CODE **4034 SUNNY DAY WAY** **KISSIMMEE, FL 34744**	

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

0000 - Initial Comments

Complaint Investigation #2019006835 was on and . Elite Manor - Kissimmee had deficiencies at the time of visit.

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

Based on record review and interview, the facility did not obtain a complete and accurate AHCA form 1823, Resident Health Assessment for Assisted Living Facilities, for 4 of 4 sampled residents (#1, 2, 3 & 4).

Findings:

1. Resident #1 was admitted to the facility on . The health assessment report used was the AHCA Form 1823, , not the required AHCA Form 1823, . The assessment was not dated. The assessment indicated she needed "total care assist bathroom". Page 2 of the assessment initially indicated she needed total care with ambulation, bathing, toileting and transferring. The check marks were crossed off and assistance was checked off. Page 4 of the assessment indicated she needed medication administration. That check mark was also crossed off and assistance was checked off.

Updated health assessment report 1823, dated , was incomplete. The assessment did not indicate if the resident was at risk for elopement and whether her needs could be met in a facility that was not a , , or nursing facility. Those portions of the assessment were blank.

On at 1:30 PM, the administrator said the assessment was incorrect; she did not need total care. The assessment was received that way when the resident was admitted.

2. Resident #2 was admitted to the facility on . The health assessment report was dated . The review revealed the health assessment form used was the AHCA recommended Form 1823, dated , and not the required AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, .

3. Resident #3 was admitted to the facility on . The health assessment form used was the AHCA Form 1823, , not the required AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, .

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4. Resident #4 had a health assessment dated . The assessment form used was the AHCA recommended form 1823, dated , and not the required AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, .

On at 1:30 PM, the administrator confirmed the findings.

Class III

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

Based on record review and interview, the facility failed to provided care and services appropriate to the needs of 1 of 4 sampled residents (#3), did not seek medical care after resident #3 sustained a with injury, did not follow the healthcare provider's order for medications, and did not notify the healthcare provider when the resident refused a medication continuously.

Findings:

Resident #3 had a health assessment dated that listed diagnoses of high , and . Per report she was calm and forgetful. She needed assistance with self-administration of medications.

A medication list, dated - was not signed. It listed Hydrochlorodiazide (HZTC) 40-12.5 milligrams (mg.) one daily, and , 20 mg. one daily hold for , or , . A prescription, dated , read , 81 mg. one daily as needed for , and , 400 mg, one twice daily as needed for , .

A healthcare provider visit note, dated , indicated the resident had 's . Some of the medications listed were , 20 mg. one daily, HZTC 40-12.5 mg. one daily and , 400 mg. one twice daily as needed. An order was for occupational and , services was also written.

A healthcare provider visit note, dated , indicated the resident had 's , had unsteady gait, and was a risk.

The and , Medication Observation Records (MORs) listed HZTC 40-12.5 mg. one daily hold for , or , had an "R" from to , had an "R' from to , and , to had an "R". No , readings were

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written. 400 mg. one twice daily as needed for was listed on the MOR, and indicated to be given 3 times a day at 8 AM, 1 PM and 8 PM. There was no evidence the healthcare provider was contacted and informed the resident's refusal of the medication or her refusal to have her taken.

was marked as given, as evidenced by staff initials on , time not indicated; from at 8 AM until , it was given 4 times a day 8 AM, 1 PM, 8 PM and another dose was given each day during that time, however the time of day was not indicated. The resident was given 400 mg. 4 times in a day from to . Another dose was given on at 8 AM. There was no evidence the healthcare provider was contacted and a revised order for was received.

The , and MOR listed , 0.5 mg. half-tablet twice daily as needed for . The medication was given twice daily as if it was a scheduled medication, not as needed. There were no notations to confirm the resident felt and requested the medication.

Facility notes indicated the following:

(Friday) Was getting ready for bed at 6:30 PM, got spell and . Roommate alerted caregiver, who helped her up, asked if she wanted to go to hospital, she said no, that she was OK, just wanted to go to bed, ice pack put on arm.

(Saturday) Her was , again she refused to go to hospital Doctor and family informed. The Power of Attorney (POA) was called. Spoke with wife - was not first time she slipped and .

(Sunday) Family visited today, was in , and receiving , medications, did not want to go to hospital (Daughter in law asked her if she wanted to go to hospital, she said no), although in , She moved around, not unusual to the way she's accustomed to.

(Monday) Doctor was called today, requested an of arm as it was still . Tthe doctor was out of town and promised to see her Friday. No order.

(Friday) Son visited, he felt she should go to hospital. POA called and send her to local hospital, Family called.

(Saturday) Spoke with POA/son - resident was admitted to hospital and will not be coming .

Son came in today and picked up belongings.

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On at 1 PM, the administrator said, "What you see is different from how we see her. She had enough of hospitals. They don't want to go. She helped fold laundry, kicked the laundry basket with the same that she broke? I felt I could listen to her. She was in some ."

Hospital record review revealed the resident was taken to the emergency room on because the son was concerned with and of the resident's right arm as well as complaints of right . Per hospital intake, she 6 days ago at the assisted living facility. was worst when areas were touched. The history and physical indicated the resident's right arm had that extended from to with soft tissue and areas of . She was alert to self, place and family only.

results, dated at 4:20 PM, indicated an acute of the (or bone). A report, dated , indicated the resident sustained a subcapital of the right .

The report, dated , indicated the resident underwent a right , hemi- , for subcapital of the right , (surgical repair of the).

On , she was discharged to a skilled nursing facility.

On at 10:50 AM via telephone, the administrator said the resident refused HCTZ because her was good. The administrator said the resdient said she did not need the medication, she also took another , medication. The unlicensed staff took her , measurements.

The facility failed to obtain prompt medical care to the resident after she , had a and arm and complained of for 6 days. The unlicensed facility staff made a judgement not to seek help based on the statements of a resident afflicted with , who may not have been able to express her level of .

Class II