Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910733	A. BUILDING: _____ B. WING _____	09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIP CARE PAVILION LLC	6810 SW 7TH STREET MARGATE, FL 33068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced licensure complaint survey, 2019009203 was on [redacted] at VIP Care Pavilion, LLC. The facility had deficiencies at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.	A 025		

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A 025	Continued From page 1 (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining 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. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide appropriate supervision for each resident. The facility also failed to Contact the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. The facility also 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 3 sampled resident records reviewed. (Resident # 1 and # 3). The findings included: On . . . . . at 09:00 AM, a tour of the facility was conducted. The observation revealed that the direct care staff was observed performing housekeeping duties, i.e. sweeping, changing beds, and taking out the trash. It was revealed that they were not providing undivided attention to	A 025		

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A 025	Continued From page 2 the residents of the Memory Care facility. On . . . . . at 11:30 AM, an interview was conducted with Staff A. She works as a Resident Care Aide, providing direct resident care. She confirmed that the Aides are required to perform housekeeping tasks. She was observed taking the large garbage barrels outside to the dumpster. On . . . . . a review of the facility . log revealed that Resident # 1 and # 3 sustained within the facility, which resulted in the emergency transport to the hospital. The residents sustained injuries which resulted in admission to an acute care unit in the hospital. a) On , a review of the medical chart was conducted for Resident # 1 and revealed the following. 1) On . . . . . , Patient (..) found on the floor in the Bathroom. The , (B/P) was high, B/S = 97. He was very . . . . . 911 was called and , . taken to Hospital. Daughter was called and notified. Wife will go to the hospital with him. No Physician notified. 2) On , Resident # 1 sustained a . . . . . ., Patient (..) was found on the floor in his room. 911 was called and Daughter called. Daughter initially did not want dad to go out but agreed with Paramedics. The Physician was not notified. On . . . . . , Daughter called and said Dad had his right . She advised Director of Nursing (DON) that he had to have surgery. On at 11:30 AM, an interview was conducted with the facility Director of Nursing (DON). She stated that Resident # 1 walked	A 025		

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A 025	Continued From page 3 around the facility in inappropriate wear (flip flops). She stated that she feels this attributed to his . She says he was an elopement risk. She says he required stand by assist. She says he suffered Moderate . The DON stated Resident # 1 sustained a on . The Resident was transported to the hospital. She says she believes he was admitted for 4 days and returned to the facility. She says the Resident had a history of problems. She stated she did an evaluation of him at the time of , and his rate was low. She stated the daughter told them that the resident did not have any new orders to return to the facility. The DON, further stated, Resident # 1 was found on the floor by direct care staff again on . She says the resident complained of in his right when she assessed him. She says the Paramedics checked him and transported him to the hospital. She says after he was discharged from the hospital, he was transferred to Rehab for . She stated the daughter told her that the resident needed surgery. She says he returned to the facility and he was using adaptive equipment (walker, wheelchair). She stated he needed a higher level of care. She stated a new Florida Health Assessment form (AHCA 1823 form was completed). A review of the (AHCA 1823 form) dated was conducted for Resident # 1. It was revealed that the Resident was admitted in . He suffers from the following diagnosis: , Major , and . Upon admission, he only required assistance with	A 025		

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A 025	Continued From page 4 the following Activities of Daily Living for bathing and . He was coded as a and elopement risk. A review of the medical chart revealed that after the resident sustained the on , the AHCA 1823 form was updated to reflect a significant change (decline in the ADL function). The updated 1823 form dated shows he requires assistance with all ADL's except eating. He is coded as a . precaution. He is no longer an elopement risk. status shows periods of forgetfulness. At this time, the resident was placed on Hospice Care. A review of the medical chart revealed that the facility did not implement steps and procedures (including increasing supervision) for Resident # 1 to reduce/prevent after and . The review of the nursing note regarding the corrective action, reads as follows: corrective action, instruct resident on calling an aide when he gets up. The updated AHCA 1823 form clearly indicated that the Resident lacked capacity to make informed decisions regarding his care, treatment and services. The interview with the facility staff revealed the resident had poor safety awareness that would prevent him form notifying staff when he gets up. A review of the nursing notes further revealed that the Resident's physician was not notified to request a medication review that may attribute to . The medical record review revealed that the request for appropriate wear was requested. The nursing progress notes also indicated the following: Emails received from daughter complaining that the facility is not doing enough for her father: , , and	A 025		

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A 025	Continued From page 5 b) On [redacted], a review of the medical record was conducted for Resident # 3. It was revealed that Resident # 3 was admitted into the facility in [redacted]. She is a [redacted] adult. The AHCA 1823 form dated [redacted] indicates the resident suffers from the following diagnosis: [redacted], and [redacted]. She walks without assistance. She is [redacted], agitated, resistant to care at times. The section for Nursing Treatment Services is empty, (It is unknown). She is not an elopement risk. The use of ½ side rails are recommended for safety. She is independent with ambulation, eating, and transferring. She requires assistance with self-care grooming. She requires supervision with [redacted], eating, and toileting. A review of the progress notes dated [redacted] reveal the Patient ([redacted]) has a right [redacted] that tends to give out. The [redacted] got up to walk and the [redacted] gave out, [redacted] to the rights side. [redacted] has a small Hematoma on upper forehead area, above the right [redacted], contacted the [redacted]'s Daughter. An additional progress note was reviewed, dated [redacted], [redacted] is seen by medical provider, she still has [redacted] and walks with a limp. Husband and daughter aware of care plan. A review of the Physician Order dated [redacted] indicated the doctor called for a Home Health Care (HHC) evaluation for [redacted]. A review of the medical record was conducted. It was revealed that notes were not entered by staff indicating the order was followed. It could not be determined if the Resident was evaluated by a Home Health agency. A review of the nursing progress notes revealed that the [redacted] did not occur until [redacted] for a [redacted] incident with Hematoma on the	A 025		

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A 025	Continued From page 6 forehead. This took place 18 days after the injury occurred. Also, there was a Physician Order (PO) for an , on . A review of the medical chart reveals that the staff did not act upon, nor carry out the Physician Orders to ensure the resident's care and safety prior to the sustained. On at 02:00 PM, a side-by-side interview was conducted with the Director of Nursing (DON). She could not locate the note following the incident that took place for Resident # 3. The medical record contains no further notes. She stated the family called her and told them that Resident # 3, her in the . They told her staff that she would not be returning to the facility. The incident was not investigated to determine the cause of the , nor the notes to indicate that the resident's family notified the facility that the resident would not be returning. She says a State Advocacy Agency also came and investigated this case on . The adverse incident form was not completed for this occurrence. The physician order for was not followed up She could not locate the third party folder to demonstrate the the PO dated . HHC for evaluation. On at 02:00 PM, an interview was conducted with the Administrator. She acknowledged the findings. Class III	A 025		

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A 165	Continued From page 7	A 165		
A 165 SS=D	429.23(&) FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1	A 165		

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A 165	Continued From page 8 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action	A 165		

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A 165	Continued From page 9 by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. 58A-5.0241 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1) above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences, for 1 of 3 sampled resident records reviewed (Resident # 1 and # 3). Cross reference A 0025. The findings included:	A 165		

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A 165	Continued From page 10 On a review of the facility log revealed that Resident # 1 and # 3 sustained within the facility, which resulted in the emergency transport to the hospital. The residents sustained injuries which resulted in admission to an acute care unit in the hospital. a) On , a review of the medical chart was conducted for Resident # 1 and revealed the following. 1) On , Patient (.) found on the floor in the Bathroom. The , (B/P) was high, B/S = 97. He was very . 911 was called and , taken to Hospital. Daughter was called and notified. Wife will go to the hospital with him. No Physician notified. 2) On , Resident # 1 sustained a , Patient (.) was found on the floor in his room. 911 was called and Daughter called. Daughter initially did not want dad to go out but agreed with Paramedics. The Physician was not notified. On , Daughter called and said Dad had his right . She advised Director of Nursing (DON) that he had to have surgery. On at 11:30 AM, an interview with the DON stated Resident # 1 sustained a on . The Resident was transported to the hospital. She says she believes he was admitted for 4 days and returned to the facility. She says the Resident had a history of problems. She stated she did an evaluation of him at the time of , and his rate was low. She stated the daughter told them that the resident did not have any new orders to return to the facility. The DON, further stated, Resident # 1 was found	A 165		

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A 165	Continued From page 11 on the floor by direct care staff again on . She says the resident complained of , in his right , when she assessed him. She says the Paramedics checked him and transported him to the hospital. She says after he was discharged from the hospital, he was transferred to Rehab for , . She stated the daughter told her that the resident needed surgery. She says he returned to the facility and he was using adaptive equipment (walker, wheelchair). She stated he needed a higher level of care. She stated a new Florida Health Assessment form (AHCA 1823 form was completed). b) On , a review of the medical record was conducted for Resident # 3. A review of the progress notes dated reveal the Patient (.) has a right that tends to give out. The got up to walk and the gave out, to the rights side. has a small Hematoma on upper forehead area, above the right , contacted the 's Daughter. An additional progress note was reviewed, dated , is seen by medical provider, she still has , and walks with a limp. Husband and daughter aware of care plan. A review of the nursing progress notes revealed that the , did not occur until for a incident with Hematoma on the forehead. This took place 18 days after the injury occurred. On at 02:00 PM, a side-by-side interview was conducted with the Director of Nursing (DON). She could not locate the note following the incident that took place for Resident # 3. The medical record	A 165		

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A 165	Continued From page 12 contains no further notes. She stated the family called her and told them that Resident # 3, ... her . . . in the . . . They told her staff that she would not be returning to the facility. The incident was not investigated to determine the cause of the , nor the notes to indicate that the resident's family notified the facility that the resident would not be returning. She says a State Advocacy Agency also came and investigated this case on . The adverse incident form was not completed for this occurrence. The physician order for was not followed up She could not locate the third party folder to demonstrate the the PO dated HHC for evaluation. On at 02:00 PM, an interview was conducted with the Administrator. She acknowledged the findings and confirmed that the facility had also failed to complete and submit a 1 day (preliminary report) and 15 day report (full report) to the agency regarding the incidents involving Resident #1 and #3. Class III	A 165		