STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964787	07/30/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Jensen Beach	1700 Ne Indian River Drive Jensen Beach, FL 34957	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced complaint survey, CCR# 2013007749, was conducted on and at Emeritus at Jensen Beach. The facility had deficiencies found at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on record review and interviews, the facility failed to ensure AHCA Forms 1823 (medical examinations) were complete and clear for two of three sampled Residents (#1 and #3); medical examination forms omitted information and/or information needed clarification related to pertinent health factors.

The findings include:

Record reviews for Residents #1 and #3 conducted identified the following concerns:

1. Resident #3's medical examination form revealed (exact date could not be determined):
a. Page 1, Medical History and Diagnoses read, - multiple soft tissue injury". Physical or Sensory Limitations and Special Precautions documented as, Hospital medical records dated showed evidence of chronic and diverticulosis.
b. Page 1, Service Requirements read, "[treatment to right] upper abdomen, [right] thigh, [left] hip (rug only)". Facility failed to clarify this requirement to ensure his individual needs were met.
c. Page 1, Resident's Height was left blank.
d. Page 1, and Behavior Status read, mini mental exam". The facility failed to clarify this and should have been in order to understand his individual needs in this area.
e. Page 1, Special Precautions listed - taking mechizine with effect". The facility failed to clarify this related to the resident's risk for .
f. There were four different versions of Page 4, one was certified by a Doctor of Osteopathy on one was certified by Medical Doctor but was not dated, one was certified by a Advance Registered Nurse Practitioner on and one had the resident's name listed at the top with no other information on the page. It was not clear which HCP actually performed each segment of the

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medical examination.
g. There was no Page 5, Services offered or arranged by the facility for the resident.

2. Resident #1's medical examination form, certified by a HCP on , revealed:
a. Page 1, Physical or Sensory Limitations did not reference her inability to verbally communicate.
b. Page 1, Special Precautions was left blank.
c. Page 2, Activities of Daily Living (ADLs) were all checked off as Independent and bracketed with the comment, "[moderate independence] needs daily supervision"; the extent of assistance was not given.
d. Page 3, Ability to Perform Self-Care Tasks read, "to be assessed in the ALF"; the HCP conducting the assessment failed to complete this section. This should have been followed up on by facility staff.
e. Page 4, Please list all current medications prescribed below read, "see MAR" but nothing was attached to the form.
f. Page 5 Service offered or arranged by the facility for the resident read, "See ISP" but nothing attached. This section was not completed and signed and dated by the assisted living facility Administrator or designee.

There was no evidence to show facility staff contacted the residents' HCP for the omitted/unclear information within 30 days of the resident's admission, or at any other time. These concerns were discussed with and acknowledged by the Administrator and Resident Care Director on at 11:05 AM. It was revealed no further information was available for review.

Class III

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review and interviews, the facility failed to provide care and services appropriate to resident needs, for 1 out of 3 sampled residents (Resident #3); facility staff failed to provide or ensure provision of Health Care Provider (HCP)-ordered supervision during ambulation.

The findings include:

Review of facility records and Resident #3's record conducted documented the following information:

1. He was admitted to the facility on

2. His AHCA Form 1823 (medical examination) was certified by a HCP in 2011 and:
a. Listed only - multiple soft tissue injury" under diagnoses. In two other places, the form disclosed,
b. Page 2, Activities of Daily Living (ADLs) had "supervise with ambulation" checked off and the comment "straight cane - [independent] in ' was written next to it.

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c. There was no Page 5, "Services offered or arranged by the facility for the resident", or other documentation of a service or care plan for Resident #3 showing the facility identified the resident's need for supervision while ambulating, the specific service facility staff would provide related to that resident need, the frequency and duration of the service to be provided, and by whom the service would be provided.

3. Three incidents wherein he [illegible] and was injured:

a. On [illegible] his Service Notes documented a [illegible] resulting in a [illegible] to the side of his head, next to his left ear. The resident's health care provider (HCP) was notified and ordered [illegible] care. On [illegible] the Service Notes documented "hematoma to [left] back of head with [illegible]. [No complaint of [illegible] or pain. There was no evidence this incident was investigated or if any interventions were considered, offered or recommended by facility staff to prevent recurrence of a [illegible].

b. On [illegible], his Service Notes and an Event Management form dated [illegible] documented he lost his balance while walking outside and received [illegible] to his right thumb and left knee for which his HCP ordered treatment. The section titled Intervention/Preventive Measures read, "walk with cane". An Event (After Hours) Physician Communication Form dated [illegible] read, " Resident went outside for walk, stated [lost his] balance [and [illegible]. Upon assessment, [illegible] on [right thumb] and [left] knee noted. Clean with N/S and ABT ointment [applied] ... please notify " [illegible]. There is no evidence showing the form was given, faxed or otherwise transmitted to the resident's HCP. There was no evidence showing any interventions were considered, offered or recommended by facility staff to prevent further recurrence of a [illegible].

c. On [illegible], his Service Notes and an Event Management form dated [illegible] documented the facility was contacted by a hospital and advised Resident #3 had been found lying in the road (0.8 miles from the facility) and was in their care. The resident [illegible] on [illegible].

In interviews conducted [illegible] at 10:05 AM, 10:13 AM, 10:39 AM and 10:45 AM, facility staff stated Resident #3 was allowed to come and go as he pleased and they would see him walking outside or smoking cigarettes outside regularly. There were no references to providing him with supervision during ambulation.

In an interview conducted [illegible] at 1:30 PM, Resident #3's family member and Health Care Surrogate confirmed he had an unsteady gait and was allowed to come and go as he pleased. She stated he would mostly walk around on the property outside, and occasionally walked to a local restaurant for a Bloody Mary (cocktail) and a sandwich.

In an interview conducted [illegible] at 10:50 AM, the Administrator and Resident Care Director acknowledged the information from the facility and resident records identified above. They acknowledged the resident was admitted with a primary diagnosis of [illegible] with multiple deep tissue injuries" and the requirement of "supervision during ambulation", his history of [illegible] during his stay at

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the facility, and the lack of a specific care plan relating to the resident's requirement for supervision with ambulation, citing neither of them worked at this facility when the resident was admitted and set up for care in 2011.

Class II

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

Based on interviews and record review, the assisted living facility (ALF) failed to honor resident rights. As evidenced by facility failure to honor a resident's , for 1 out of 3 sampled residents (Resident #1).

The findings include:

Review of Resident #1's record revealed she was admitted to the ALF on . Her AHCA Form 1823 (medical examination) dated documented diagnoses of recurring prior (high , and multi-level sponclyosis. Further record review revealed the following:

1. A gold-colored "DH Form 1896 signed by Resident #1 and a Physician on , the resident's initials and were written next to the date. The form documents the resident's direction that may be withheld or withdrawn, and further instructs, per F.S. 401.45, a copy or original of this may be honored by hospital emergency services, nursing homes, assisted living facilities, home health agencies, hospices, adult family-care and emergency medical services.

2. Resident observation notes, or Service Notes documented:
a. On at 5:30 AM, "[Medication technician] sent resident to [hospital emergency via 911 increased unable to stand, [Advance Registered Nurse Practitioner] notified."
b. On at 2:30 PM, "Per [hospital], patient to be admitted to hospital. "
c. On , "Teleconference with [Case Manager] at hospital, resident in critical condition, intubated and in surgical intensive care, [Administrator] reports speaking with son today via telephone."
d. On , "Advise resident expired by call placed to receptionist today. "

3. A facility form titled Event Management dated documented on at 5:30 AM, "Resident called staff, not feeling well, and said she was feeling weak. Med tech called 911 and son." The Disposition read, "ER visit". The form was not signed as being completed by the Resident Care Director and/or licensed professional, or reviewed by the Executive Director and Resident Care Director.

4. A facility form titled Event Investigation dated at 2:00 PM documented, "On the above date and time, a called was received by [facility staff] from family member of [Resident #1]. Caller stated

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that resident was unresponsive and [redacted] while hospitalized at [hospital]. Caller indicated she believes the facility staff failed to communicate a valid [redacted] via [redacted] (911) when resident was sent to emergency [redacted]." The section titled Conclusions regarding the cause of the event read, "[Staff] stated she did not recall sending [redacted] order to the hospital with paramedics." The section titled Corrective Action Taken was left blank. The form was not signed by the facility's Executive Director.

Review of hospital medical records for Resident #1 documented:

1. The following documents were identified as three documents received from the ALF at the time of Resident #1's arrival to the hospital on [redacted] at 6:25 AM:
a. Resident #1's Resident Identification and Emergency Information page which included a box checked off to indicate she had a [redacted]. There was no actual [redacted] form attached.
b. Two pages of Medication Observation Records
c. Two pages with insurance card information

2. An Emergency Medical Technician report documented the patient's chief complaint as, [redacted], no other pertinent information was included in this report.

3. An Emergency Department entry dated [redacted] at 6:25 AM documented, "Arrived [emergency department] via [redacted], no yellow [redacted] with patient. Patient admitted, family notified.

4. Nurse Notes documented:
a. On [redacted] at 7:45 PM, "... Son informed Patient is Florida [redacted] but only if [redacted] ill, she is stable, leave her post status as she is and he will bring in power-of-attorney and living will paperwork tomorrow."
b. On [redacted] at 11:45 PM, "Nurse did assessment, pre-existing [redacted]/living will, made notation to notify MD about order."
c. On [redacted] at 2:52 PM, "She coded, was [redacted], intubated, put on [redacted] and transferred to [redacted]"
d. On [redacted] at 4:10 PM, "Transferred from 5E [redacted] intubated code blue. "
e. On [redacted], no time listed, "Son signed assumption of surrogacy; MD declared Patient [redacted] can not recover, [redacted] condition, instructions for life support to be withheld", and was signed by the Son.
f. On [redacted] at 6:00 PM, "Extubated, weaned patient off [redacted], she continued to breath."
g. On [redacted] at 7:40 AM, "Patient [redacted]

5. A [redacted] 4:10 PM Case Manager note included, "Patient transferred from 5, intubated on [redacted] following code blue, son arrived with ptient's yellow [redacted] to our surgical [redacted], he does not understand why yellow [redacted] from the facility did not accompany the patient when she came to the hospital. [Facility Nurse Manager] called inquiring about patient, son allowed Case Manager to ask him about the [redacted], [Nurse Manager] stated they are looking into the circumstances. Son stated, "the patient did not want to be intubated or placed on [redacted] Nursing has called Physician for orders for comfort measures and possible extubation."

In an interview conducted [redacted] at 11:05 AM, the Administrator and Resident Care Director, based

on the information contained in the Event Investigation form, acknowledged facility did not follow facility protocol and ensure the resident's was transferred with the resident on The Administrator stated she did not work here at the time of this incident; the RCD stated this was handled by the prior Administrator.

Class III

0160-Records - Facility 58A-5.024(1) FAC
Based on record review and interviews, the facility failed to ensure major incidents were properly investigated and documented, for 2 out of 3 sampled residents (Resident #1 and #3).

The findings include:

Record reviews for Residents #1 and #3 conducted identified the following concerns:

1. Facility records and Resident #3's record revealed he experienced major incidents on three occasions, noted concerns included:
a. On his Service Notes documented a resulting in a to the side of his head, next to his left ear. The resident's health care provider (HCP) was notified and ordered care. On the Service Notes documented "hematoma to [left] back of head with [No complaint of or pain.
b. On his Service Notes (and an Event Management form dated documented he lost his balance while walking outside and received to his right thumb and left knee for which his HCP ordered treatment.
c. On his Service Notes (and an Event Management form dated documented the facility was contacted by a hospital and advised Resident #3 had been found lying in the road and was in their care. The Resident on

2. Facility records and Resident #1's record revealed she experienced a major incident on when a cat scratched her hand and a HCP prescribed an for treatment. Further record review revealed no additional information or documentation related to this incident.

Review of the aforementioned documentation, revealed the information was incomplete. The Event Management forms were signed by the Resident Care Director and/or licensed professional, or reviewed by the Executive Director and Resident Care Director. There was no evidence to show facility staff had properly investigated the incidents and documented some or all of the required components of the investigations including: a clear description of what happened and underlying causes for the , the places where the incidents occurred, names of any individuals involved, any witnesses or witness statements, any description of medical or other services provided by facility staff, steps taken to prevent recurrence of and as applicable, escalation of interventions when the resident experiences repeat incident

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These concerns were addressed with the Administrator and Resident Care Director on . . . . at 10:11 AM. The facility, after multiple unsuccessful attempts to locate related documentation, they determined the documents were either deemed lost or were never completed in the first place.

Class III

0162-Records - Resident 58A-5.024(3) FAC
Based on record review and interviews, the facility failed to maintain resident records as required for 2 out of 3 sampled residents (Resident #1 and #3). As evidenced by the facility failure to maintain health care provider (HCP) orders and other pertinent documentation.

The findings include:

Record reviews for Residents #1 and #3 conducted identified the following concerns:

1. During review of Resident #3's records, multiple requests were made for records including written HCP orders, medication observation records, service plans, resident observation notes, HCP progress notes, laboratory test results, and major incident investigations. The facility staff made multiple unsuccessful attempts to locate the requested documentation. In an interview conducted . . . . . at 3:05 PM, the Administrator and Resident Care Director (RCD) stated the records were deemed lost, it was believed a prior employee was responsible.

2. During review of Resident #1's records, a request for her 2013 medication observation record and a incident (in which resident obtained injuries from an animal) investigation record were made. The facility staff made multiple unsuccessful attempts to locate the requested documentation. In an interview conducted at 3:05 PM, the Administrator and Resident Care Director (RCD) stated the records were deemed lost or not completed; they had no further explanation for what may have happened to the records.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Emeritus at Jensen Beach
1700 NE Indian River Drive
Jensen Beach, FL 34957

Dear Administrator:

Re: CCR #2013007749

This letter reports the findings of a state complaint survey that was conducted on , 2013 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , **2013** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at 561 381-3850.

Sincerely,

Arlene Mayo-Davis
Field Office Manager
Division of Health Quality Assurance

AMD/
Enclosure