

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11964446	(X3) DATE SURVEY COMPLETED 06/26/2014
NAME OF PROVIDER OR SUPPLIER Isles Of Vero Beach	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 Waterford Drive Vero Beach, FL 32966	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0000 - - Initial Comments

St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D

St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced Assisted Living Facility (ALF) complaint inspection (CCR #2014006200) was conducted on 6/24-26, 2014. Isles Of Vero Beach had deficiencies found at the time of the visit.

This inspection was conducted in conjunction with a Capacity Increase Survey on the same dates. Please refer to the separate report for the findings.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on record review and interviews, the facility failed to ensure residents were monitored for continued residency at all times in relation to pressure sores and/or significant changes; and to discharge a resident which no longer met the criteria for continued residency, 1 out of 2 sampled (Resident #10) .

The findings include:

On 6/24/2014 at 3:00 PM, the Director of Nursing (DON)/Licensed Practical Nurse (LPN) stated during interview, that there were no residents in assisted living with pressure sores. She stated Resident #10 had recently required more assistance with transfers and notification of relocation had been given to the resident's responsible party related to this. Review of the home health agency (HHA) notes at the facility for Resident #10 revealed a _____ pressure _____ cared for by a registered nurse (RN) since _____. The RN was interviewed on 6/25/2014 at 2:45 PM and acknowledged the resident had a _____ or unstageable pressure _____ on the left heel upon admission to the assisted living facility (ALF) on 6/24/2014 and that the pressure _____ on the resident's left heel had not improved to a _____ pressure _____ since admission.

The resident's health assessment (AHCA Form 1823) signed by a physician and dated 6/24/2014 noted the resident had "no _____, 3 or 4 pressure sores" but had "continued RN with home health care (HHC)" listed as a nursing service. A subsequent assessment signed by the same physician and dated 6/25/2014 noted the resident had "no _____, 3 or 4 pressure sores" but had documentation that the resident had a "lower left extremity (LLE) _____ (heel) unstageable". The resident's record also contained an ARNP's

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(advanced registered nurse practitioner) note dated ... that the resident had a ... sacral ... and heel ... with no additional details. Further record review of Resident #10's file, failed to indicate any documentation regarding any evaluations conducted by the facility to ensure the resident met the criteria for continued residency upon significant change regarding the pressure sores.

During interview with the HHA RN as noted above, she confirmed that the last note written by her on ... showed the resident currently has a ... pressure ... on the left heel and a ... pressure ... between the toes on the left foot (not on the sacrum). The date of onset for the ... pressure ... was unknown and not documented in the resident's record.

These findings were acknowledged during interview with the Administrator on ... at 5:00 PM. The Administrator also confirmed that Resident #10 was not enrolled into Hospice Care and no longer met the criteria for continued residency.

Class III

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

Based on record review and interviews, the facility failed to ensure at least 45 days' written notice of relocation or termination of residency was given to 1 of 1 sampled residents (Resident #10) who had been determined to be inappropriate for assisted living facility (ALF) residency.

The findings include:

On ... at 3:00 PM, the Director of Nursing (DON)/Licensed Practical Nurse (LPN) stated during interview that Resident #10 had been determined to require a higher level of care than an ALF could provide related to the resident's decreased ability to ambulate and transfer with assistance. She confirmed that the only written information pertaining to the resident's notice of relocation (discharge) was an email communicating this to "corporate". The resident's responsible party was interviewed on ... at 12:15 PM and stated the discussion with the DON about the resident's need to relocate within 45 days took place on or about ... but had not received a written notice of discharge. During review of the resident's record, there was no written notice of relocation from the facility available for review. This was acknowledged by the Administrator during interview at 5:00 PM on ...

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Isles Of Vero Beach
1700 Waterford Drive
Vero Beach, FL 32966

RE: CCR #2014006200

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2014 by a representative from 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 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) 381-5840.

Sincerely,


Arlene Mayo-Davis
Field Office Manager

AMD/dso

Enclosure: State form 5000-3540

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