STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911395	03/18/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Residential Plaza At Blue Lagoon	5617 Nw 7 Street Miami, FL 33126	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0010 - 429.26(1&9) Fs; 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0051 - 58a-5.0185(2) Fac - Medication - Pill Organizers S-S= D
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments

A Complaint (CCR# 2015001397) Investigation Survey was conducted on , 2015 and concluded on , 2015. Residential Plaza at Blue Lagoon had the following deficiencies found at time of the survey:

0010-Admissions - Continued Residency 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the facility failed to have a updated health assessment after residents had a significant change in medication assistance for 1 out of 6 (#1) sampled residents.

Findings included:

Resident record review for Resident #1 showed that he was admitted to the facility on The Health Assessment dated indicated the resident was diagnosed with . The health assessment documented under nursing treatment/ service requirements that the resident needed assistance medications. The physician documented the resident needed assistance with his medications in the Section 1 and then documented that the resident was independent with his medications in Section 2, B.

Review of Resident #1's progress notes showed Staff B, a Registered Nurse, documented on and . "I prepared pill box. The resident reported to be taking all his medications". On "The resident was found on the floor in his living . The resident had problem communicating. Fire rescue was called and the resident was transferred to the hospital." on "The resident came back from the hospital". On "I went see the resident in his . The resident was hospitalized due to toxicity. He had taken the medications for Tuesday and Wednesday incorrectly. The resident asked me if I could fill pill organizer on a daily manner from Monday to Friday and pre-fill Saturday and Sundays. I asked the resident to double check pill organizer before taking his medications." On / and / "I prepare pill organizer for today date and I prepared a weekly pill organizer for med tech to give to the resident as ordered."

Interview with Staff B, a Registered Nurse, on PM revealed that Resident #1 was independent with his medications before he got intoxicated. She stated "I prepared the pill organizer and the facility staff assisted him with his medications."

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The facility did not have a new health assessment completed after Resident #1 was hospitalized on

Class III

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

Based on observation, interview, and record review, the facility failed to provide daily supervision by designated staff of the activities of the residents while on premises for 2 out of 6 (#1 and #2) sampled residents that were in a physical altercation. The facility failed to ensure that residents were supervised in the activities . The facility failed to contact the residents health care provider and conduct a complete assessment for 2 out of 6 (#1 and #2) sampled residents after a physical altercation.

Findings included:

Observation on at 1:15 PM to 3:45 PM showed 20 residents sitting at the table playing dominos. There was no facility staff member supervising the residents, resident were observed getting loud during the game.

A local hospital record review showed Resident #2 was admitted on at 12:32 AM. The hospital records documented the resident had informed hospital staff that he had an altercation with another resident after disagreement in dominoes game. He was diagnosed with an injury to the head, the elbow, the , and the wrist. He had without . The patient had a history of and and of large intestine. The physical exam documented that the resident had faded to upper abdomen. And numerous old present to the chest (multiple stages of healing). The Right elbow had a small . He had a minor closed head injury. He had an of upper aspect of the right ear. Resident #2 was discharged home on at 3:06 AM, in stable condition.

Review of Resident #2's record on at 10:45 AM. showed the health assessment dated indicated the resident was diagnosed with moderate progressive, , and by the physician. The health assessment documented that the resident needed assistance with eating and supervision with ambulation, bathing, , toileting and transferring. The resident required 24 hours nursing or care (The facility was not able to provide 24 hours nursing or).

Resident #2's progress notes dated documented, "I saw the resident in the elevator and notice on right ear. I took him to my office and ask him what happened and he told me he did not remember. No pain, no open wounds noted. I instructed the resident to report and pain, , to healthcare department proximity vs WNL (within normal limits)" written by a registered nurse.

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Resident #2's case manager documented on that he informed the resident's family member about the incident that occurred last Sunday. The incident was under investigation. Resident's #2 family members came and wanted to know what happened with the resident because he had in his right ear and in his arms. Resident #2's family members called the police and took the resident to the hospital.

On , Staff A, the Administrator documented Resident #2's family members were upset. The facility was in the process of interviewing residents and reviewing cameras.

An interview was conducted with Resident #2's family member on at 12:20 PM. She stated, Resident #2 is residing in her home. He is doing well. She stated, she received a phone call from Staff H, the case manager, to inform her that he fought when he was playing dominoes last Sunday but was doing fine. She asked Staff H if he received any assistance and if the facility contacted the police. He told her that Resident #2 was doing fine and they did not contact the police. She stated, "I went immediately to the facility. Resident #2 ear was black and he had and scratches on his body. She contacted the police and took him to the hospital for an evaluation. She told Staff H that she wanted to see the video recorder and the results of the investigation in order to know what happened with his friend. She stated, until today no one from the facility had contacted her."

Review of the facility's internal incident dated documented, "I went to see the resident at his . Follow up (administrator and nurse) report about what had happened between the resident and another resident on Sunday. I performed a general assessment and noticed a on right ear. No open skin, no pain reported at that time. I instructed the resident to always notify the health care department of any incidents he may have for us to be able to assist him. The resident reported to be feeling well and that the incident that occurred on Sunday and was simply a fight between friends."

On at 11:00 AM Staff B reported, "When I assessed him I saw on his right ear. They were dark purple. There was no open skin. On his chest I saw purplish, yellow on his chest area. He had no pain. He was able to do range of motion of all the extremities. The physician was not notified. I came to know this because the social worker contacted me. It had already happened. There was nothing the physician could do. The cameras were reviewed ." She stated that she did not document on the facility's internal incident sheet. She stated, "That was my mistake. I should have documented everything."

Resident #1's progress notes dated / , documented Staff H went to see Resident #1 and asked him what happened last Sunday. He reported that they were playing dominoes and Resident #2 did not want to follow the rules and got aggressive destroying the game which made him react and hit him in the chest. He stated, he did not report the incident. The facility's Administrator was notified. Case will be discussed this Friday in case review. The staff reported that the resident had been arguing with the

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staff on . The police interviewed the resident regarding the altercation that occurred last Sunday. The resident stated that he was offended and admitted that he hit Resident #2. The resident will receive a warning letter since this is not acceptable behavior on .

During an interview on at 11:00 AM, Resident #1 stated, "I had an incident with a guy who was . It happened around 2:30 PM to 3:00 PM on the second floor where the domino tables are. I usually play from 1:00 PM to 4:00 PM every day. There was no staff present in that area. Resident #3 was sitting at the table with me. There were four people playing at the table. There were eight to nine people around. Resident #2 walks with walker assistance. I told Resident #2 that he needed to pay a dime to play with us. I did not know Resident #2 was . Resident #2 got mad and threw the domino pieces at them. I punched him on his chest and he started to scream and said take this guy away from me; he is going to kill me. One of the men who were sitting at the other table separated us. A few days later the police came and talked to me. The police came I think on Wednesday night with the night supervisor. The facility gave a warning.

During an interview on at 11:30 AM, Resident #3 stated, "We play dominoes daily on the second floor from 1:30 PM-4:00 PM. No staff was in that area at any time. When you play dominoes you need to show your dominoes pieces and Resident #2 refused to do it. Resident #1 stood up and asked him to show his domino pieces and Resident #2 stood up and tried to hit Resident #1. Resident #1 hit him and both on the floor. They fought on the floor. The people separated them. Two or three days after the incident a police came and asked me some questions."

During an interview on at 2:37 PM, Staff A, the Administrator stated, "I reviewed the camera's and saw that the residents were playing dominoes. Resident#2 was playing, he stand up and destroyed the game. Resident #2 tried to hit Resident #1 and Resident #1 hit him and they on the floor. One of the residents stood up and finished the fight. We never contacted the resident's physician. The administrator stated that they gave a warning letter to Resident #1 that if the event occurs again he needs to move out."

Record review of the facility's policy titled, "Adverse Incident Reporting Policy" dated showed that an adverse incident is defined as any events reported to law enforcement. The facility will protect the resident from additional harm. The administrator or designee will initiate an investigation. All staff on duty must be interviewed or complete a written statement. Other residents in the area or witnesses to the incident will also be interviewed. The facility will notify the physician immediately, and document the notification. The facility did not have documentation that the physical altercation between Residents #1 and #2 was investigated by interviewing the residents, calling law enforcement, and notifying both residents' physician immediately.

During an interview conducted on at 10:27 AM, Staff H, the Social Worker. He stated, he

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observed the video recorder with the facility's Administrator. There were four residents playing dominoes and some residents observing them. I did not recognize all of them. I recognized Resident #1 and Resident #3. I did not recognize the other residents. Resident #2 was observed sitting for the game. He was agitated. Resident #2 stood up and tried to hit Resident #1 who hit him back. Another resident separated them and turned and kept playing. He called Resident #2 family members. He did not document what he observed in the video.

During an interview on at 11:07 AM, Resident #5 stated, that she is in charge of doing the list of the residents that play dominoes. I do the list from Monday to Saturday. Resident #2 likes to tease the people, but he is not violent. There is no staff was in the domino area.

During an interview on at 11:24 AM, Resident #4 stated, "I play dominoes every day from 2:00 PM to 4:00 PM. There was no staff was in the facility (activities) Saturday and Sunday."

During an interview on at 11:47 AM, Staff G, the Activity Director, stated we have two staff in charge of the facility's activities, no one is there on Sundays and only one staff works on Saturday's. On Monday I was informed that something happened on the Sunday of 2014 (date unknown). We did an internal report. The Coffee shop, beauty salon and not opened on Sundays. The facility's domino opened on Sunday.

Interview conducted with Staff F, a team leader, on at 12:45 PM stated, "I am a floater from 6 PM-7 AM. I was working and one night Resident #2's family members came and asked me what happened in the facility a few days ago. I did not know that Resident #2 had an argument with another resident a few days ago. Resident #2's family member called the police. I went with the police to Resident #1 and Resident #3 . Resident #2 told the police that he was fine. He stated that the fight was between friends and nothing happened. Resident #2 did not hear well, you need to speak loudly. He did not have any in her face and arms."

During an interview on at 1:06 PM with Resident #2's family friend, she said, Resident #2 had hearing problems for many years. He did not like to use the hearing aid. He is able to understand you when you scream or speak close to him because he can read your lips.

Class II

0051-Medication - Pill Organizers 58A-5.0185(2) FAC

Based on record review and interview, the facility failed to ensure that residents who self administers medications were able to use pill organizers for 1 out of 6 (#1) sampled residents.

Findings included:

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Resident record review for Resident #1 showed his Health Assessment dated indicated the resident needed assistance with his medications in the Section 1 and was independent with his medications in Section 2, B.

Review of Resident #1's progress notes showed Staff B, a Registered Nurse, documented on and . "I prepared pill box. The resident reported to be taking all his medications". On "The resident was found on the floor in his living . The resident had problem communicating. Fire rescue was called and the resident was transferred to the hospital". On "The resident came back from the hospital". On "I went see the resident in his . The resident was hospitalized due to toxicity. He had taken the medications for Tuesday and Wednesday incorrectly. The resident asked me if I could fill pill organizer on a daily manner from Monday to Friday and pre fill Saturday and Sundays. I asked the resident double check pill organizer before taking his medications." On / and / . "I prepare pill organizer for today date and I prepared a weekly pill organizer for med tech to give to the resident as ordered."

Interview with Staff B, a Registered Nurse, on PM revealed that Resident #2 was independent with his medications before he got intoxicated. She stated "I prepared the pill organizer and the facility staff assists him with his medications."

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview the facility failed to complete and submit one day and fifteen day adverse incident report 2 out of 6 (#1 and #2) sampled residents that were in a physical altercation.

Findings included:

Record review of the facility's policy titled "Adverse Incident Reporting Policy" dated showed that adverse incident is defined as any events reported to law enforcement. The facility will protect the resident from additional harm. The administrator or designee will initiate an investigation and will inform AHCA. All staff on duty must be interviewed or complete a written statement. Other residents in the area or witnessed to the incident will also be interviewed. The facility will notified the physician immediately, and document the notification.

Review of Resident #2's Hospital record on at 1:30 PM, showed that he was admitted to the hospital on at 12:32 AM. He reported that he had an altercation with another resident after disagreement in dominoes game three days ago. He was diagnosed with injury to ow, , and wrist. He had without . The patient had a history of 's and of large intestine. The physical exam documented that the resident had faded to upper abdomen. He had numerous old

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present to the chest (multiple stages of healing). Right elbow had a small . He had a minor closed head injury. He had an of upper aspect of the right ear. Resident #2 was discharged home on at 3:06 AM. He was in stable condition.

Record review found that Resident #1 and #2 were in a physical altercation on . Resident #2's family member called the police and the incident was investigated.

Interview with Staff A, the Administrator, on at 2:37 PM, she stated "I reviewed the camera's. The residents were playing dominoes. Resident #2 was playing, he stand up and destroyed the game. Resident #2 tried to hit Resident #1. Resident #1 hit him and they felt on the floor. Another residents stand up and finished the fight. The recorder was only kept for one month. We never contacted the resident's physician. We did not submit the one day and fifteen days adverse incident report.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

', 2015

Administrator
Residential Plaza At Blue Lagoon
5617 Nw 7 Street
Miami, FL 33126

RE: CCR #2015001397

Dear Administrator:

This letter reports the findings of a Complaint Investigation survey that was conducted on 05, 2015 and concluded on ', 2015 by representative(s) 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.

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 surveyor(s). Should you have any questions please call Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure
XG90

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Residential Plaza At Blue Lagoon
5617 Nw 7 Street
Miami, FL 33126

Dear Administrator:

This letter reports the findings of a Complaint (#2015001397) Investigaiton survey conducted on , 2015 and concluded on , 2015, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within 10 days of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0010 - 429.26(1&9) Fs; 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0051 - 58a-5.0185(2) Fac - Medication - Pill Organizers S-S= D
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

1) A25 – Resident Care – Supervision – Class II:

- The facility must hire staff to supervise residents during times activities are conducted on second floor. The facility must designate specific responsibility to every employee for the observation and supervision of every resident to ensure their safety and wellbeing in the facility. There must be documentation of rounds done with staff name, signature, time, and date when supervision is done. This shall include sufficient facility documentation to inform others in the facility of resident's whereabouts that will ensure the safety and wellbeing of every resident. **This shall be completed by** .

- The facility's policies and procedures for handling adverse incidents must be reviewed by staff members. The facility must train staff on the policies and procedures of incidents. The facility must show documentation of the training completed in each staff file. **This shall be completed by** .

2) A10 – Admissions – Continued Residency – Class III:

- The facility must ensure residents have a face to face medical examination by a health care provider after a significant change. **This shall be completed by** .

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com

3) A051 – Medication –Pill Organizers - Class III:
The facility must ensure that all residents that use pill organizers are able to self-administer their medications. Resident health assessments must documented what type of assistance is needed with medications. **This shall be completed by** .

4) A165 – Risk Management and Quality Assurance - Class III:

- The facility is required to maintain and report adverse incident reports to the Agency. **This shall be completed by** .

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact . Laura Manville, Survey and Certification Support Branch, at (727) 552-1955 or Verlande Exil, Health Facility Evaluator Supervisor, Miami, (305) 593-3100

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

D7JR