STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964990	10/14/2016
NAME OF PROVIDER OR SUPPLIER **EMERALD PARK RETIREMENT, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **5770 STIRLING ROAD HOLLYWOOD, FL 33021**	

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

0000 Initial Comments

An unannounced licensure complaint survey, CCR #2016008066, was conducted on 10/14/2016. Emerald Park Retirement, LLC (License #9431). The facility had a deficiency at the time of the visit.

0025 Resident Care - Supervision

Based on record review and interviews, the facility failed to ensure that appropriate supervision is provided to all residents during transportation on the facility bus, 1 out of 1 resident (Resident #1) who rode on the facility's bus on . As evidenced of Resident #1 being left on the bus unattended; the resident attempting to get help on the bus and 3 bones.

The findings included:

Review on , it was reported that Resident #1 was taking out of the facility on an outing. Upon returning to the facility, she was left or forgotten in the facility van for nearly half an hour. Unfortunately, while trying to reach the wheel to blow the vehicle horn, Resident #1 and one of her legs.

Review of Resident #1's record documented that she was admitted to the facility on / . Resident #1's Health Assessment (AHCA form 1823) dated revealed the following diagnoses: history of , Right Hip, ORIF, Intramedullary nail arms unspecified. Further review of the AHCA form indicated that Resident #1 was alert and oriented to people and place and had moderate in decision making. She required, total care for ambulation, bathing, assistance for dressing, supervision for self-care and she was independent for eating.

During an interview with the Executive Director (ED) on at 1:34 PM, she explained that Resident #1 was accidentally left in the community bus on , 2016. She said the resident as she was trying to reach the horn of the van to alert someone to come to assist her. She explained that the resident had a hair salon appointment on that day and left the facility at about 10:00 AM. When the driver returned to the facility another vehicle was parked in the lobby area, where he usually stationed the bus, so he ended up parking the bus at a different location. The Administrator stated that this change in the driver's routine might have been the cause of him forgetting about the resident in the bus. She stated that when they found the resident she was in pain and was lying on the floor of the van. After bringing her inside, they her and immediately contacted the physician who ordered an X-ray of the leg. However, it was taking too long for the X-ray Company to arrive, they called the ambulance and sent Resident #1 to the hospital, for she was in too much pain. She stated that Resident #1 stayed in the hospital for a while. Then, she was transferred to a rehabilitation center for recovery. She said that the resident was left in the bus for about 30-40 minutes. As a result of this incident, the Administrator

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reported that the employee (Driver #1) was terminated. According to the Administrator, the resident is still in the rehabilitation center.

During an interview with Driver #1 on at 2:00 PM, he reported that in he took a resident out of the facility to a beauty parlor. He stated that prior to that day the door of the van had been getting stuck from time to time and would not close or open when he pressed on the control. On that day, when he returned to the facility, he opened the door for the resident to get out, but someone else's car was parked at the lobby preventing the resident from getting off the bus. So, he decided to park the van, but the door would not close. After he parked he tried to close the door. After trying for a while, the door finally closed; he said he left thinking that the resident had gotten off the bus. He reported that he was not sure if the resident was asleep or had lowered her head in the van during that time. He did not see the resident on the bus. After he left the bus, he started helping with lunch set up, about half hour later, someone asked him if he had seen the resident. He told the staff member that the resident probably went to her . However, the resident was not in her . They later found the resident on the floor of the van, injured. They took her inside and she was complaining of pain. When asked if there was a system in place for him to document when the residents left and when he returned with them, he informed there was not a system like that. He indicated that he usually simply sign in and out when he took a resident out. He stated that this was the first time that this incident had happened.

During an interview with the new Driver #2/Activity coordinator, on at 3:00 PM, she reported that she recently was trained to become the new driver. She said the new system in place consist of ensuring that all residents scheduled to go on outings are registered. Then, before the trip she and another staff member must take a count of all residents on the list to make sure that all are accounted for. The front desk clerk goes with her to the bus after everyone is loaded on the bus to process a head count. After they both verify the number of residents in the bus, they sign on the log. Then the same process is repeated when she returns to the facility with the residents. Everyone is counted twice to ensure that everyone has returned to the facility. She said that they are very strict about transportation of the residents after the last incident.

During a confidential interview it was revealed that as a result of the incident the resident had surgery and she had broken three bones of her leg (the femur, and the). They placed two metal rods in her upper and lower leg and she will be returning to the facility tomorrow . It was revealed that the facility had explained what had happened; they had forgotten her in the bus.

Review of the facility's transportation protocol in chapter 5 of their transportation manual outlined that drivers who transport residents are supposed to register the name of each resident being transported in a transportation log before departure, and sign on the log before leaving and upon returning to the facility to make sure that all residents are accounted for. The manual documents the following:

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A Passenger log from (RE-015) should be on the bus for roll call, and a copy of the log should be at your Community in case the list is misplaced, or in the event of an accident. This is an easy way to make sure everyone who is supposed to be leaving is on the bus, and confirms that everyone has been picked and returned.

A request to review the transportation log from the Administrator for , was not available. The Administrator reported that the record for that day could not be located or it was not completed.

Review of the previous and subsequent logs dated , , ; / and revealed that the form only included the residents' name and their destination, it did not include a return time. There was no method to verify whether the residents who left the facility had returned to the facility. The facility's modified appointment form was subdivided in four columns contrary to 9 columns in the original or from the company's proposed sample form. The modified form included a Time column (out of the facility), Resident Name Column, Dr. Name, Address, phone number column, and Transport pick-up time column. The original sample form that was supposed to be used included a "Leave at column, Resident's Name column, Appointment Time column, Address dropped at Column, Time column, Dr. Phone # column, Time resident called, Time Picked Up and Time Done Column.

During the exit meeting with the Administrator, she verified that a new simplified Passenger Log will be implemented that include a column for resident's name, Activity/Appointment, Time out, Time in, Driver's Check and Resident's initial at the front desk. The Administrator informed that this new form will be implemented immediately and will replace all previous passenger logs.

CLASS III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Emerald Park Retirement, LLC
5770 Stirling Road
Hollywood, FL 33021

RE: CCR #2016008066

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2016 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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
Enclosure

XG90

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