STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953616	01/17/2018
NAME OF PROVIDER OR SUPPLIER **FIVE STAR PREMIER RESIDENCES OF HOLLYWOOD**	STREET ADDRESS, CITY, STATE, ZIP CODE **2480 NORTH PARK 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# 2017012102, was conducted on at Five Star Premier Residences of Hollywood, License #5622. The facility had deficiencies at the time of the investigation.

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

Based on record, interview and observation, the facility failed to provide appropriate supervison to a resident that was diagnosed with and demonstrated signs/evidence of , for 1 out of 3 sampled residents' files reviewed (Resident #1) .

The findings included:

Review of the facility Incident Log Report was conducted and revealed an incident regarding Resident #1. The report dated revealed that Resident # 1 was discovered entering the main lobby, using her walker, from her right leg. The incident was documented at 06:30 PM. The incident report revealed that the Resident had left the building without Staff knowledge. The report does not indicate the amount of time the Resident had been outside of the building, nor the details of her elopement attempt.

Review of the Health Assessment form (form 1823), dated for Resident # 1, revealed the resident suffers from , , , , , and a History of . She has limited ambulation and . Her cognition and behavioral status notes she is forgetful with . She also requires oversight. She uses a walker for ambulation assistance.

On at 10:15 AM, an initial request for the incident investigation report (detailed report) was made to the Administrator and the Executive Director regarding Resident #1 incident that occurred on . The Administrator nor the Executive Director, upon request did not provide a copy of the internal investigation that was conducted by the facility in order for the surveyor to further evaluate the incident regarding Resident #1. The surveyor made multiple request for the information on .

A review of the progress note dated /2017, documented the Resident was outside of the building after her daughter's visit. The note stated the Resident sustained a to her right leg approximately 2 inches in length, that required treatment by the Nurse. The Nurse on duty stated she gave the Resident First Aid. She also notified the Resident's daughter and the Resident's Physician. The progress note does not include the time of the entry or the time of the incident.

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On at 04:19 p.m., the surveyor made a final request for the detailed incident report regarding Resident #1. The Surveyor was advised that their Corporate policy stated that this information was not to be provided to the State Agency. The surveyor was unable to determine what staff or residents were interviewed and/or what documentation was used by the facility to determine outcome of the investigation due to the facility failure to provide requested documentation. Furthermore, the surveyor was unable to determine whether the facility had throughly investigated the incident and implemented steps to prevent reoccurence. The facility was also unable to demonstrate that the incident had been evaluated with respect to the future level of care required by the resident as a result of aforementioned incident.

A review of the facility Elopement policy (titled Wandering and Elopement) dated stated the following. Elopement - Attempt - when a Resident without supervision is exit seeking or attempts to leave the community/secured area, but does not cross the threshold of a secured area.

A review of the Grievance Report completed by the Corporate Executive, stated the facility determined the Resident did not outside. An interview with the Nurse on duty at the time of the incident stated she went outside and saw a trail of on the steps of the outside door. She says she concluded this is where Resident # 1 was injured. The Grievance report also indicates the facility determined the Resident was not outside for more than 15 minutes. Based on interviews with Direct Care Staff and the Concierge on the front desk at the time. No one was aware that the Resident had left the building, nor the extent of time she had been missing. The report stated that the Resident self-directed her return. In an interview with the Concierge on duty at the time, she stated a visitor noticed the Resident wandering in the parking lot and redirected her to the main entrance.

On at 02:30 PM, an interview was conducted with Resident # 1. She was asked how long she had been in the facility. She responded that she did not know. She stated she was there while her kids were in school and her husband was at work. She stated she did not know the name of the place, nor what she resided. She says she has kids, but she does not recall her daughters' name. She says her Son was outside playing. She pointed to the walker and indicated she has to use this "thing" to walk, but she did not know the name for it. She stated she did not recall leaving the building or hurting her leg.

On at 03:34 PM, a confidential interview revealed the following. The confidential interviewee stated between 05:30 PM - 07:30 PM, a visitor in the parking lot helped Resident # 1 into the main entrance. The visitor stated he saw her wandering in the parking lot injured. She stated she noticed on her right leg and helped her enter the building. The Licensed Practical Nurse (LPN) on duty was notified and that I was never interviewed by anyone in Administration or Corporate regarding the

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incident.

On at 03:35 PM, an interview was conducted with the Licensed Practical Nurse (LPN). She stated she was notified by the Concierge of the incident involving Resident # 1. She sated she helped her to her , cleaned her up, provided First Aid and put her to bed. She stated she made proper notifications to the Resident's Physician and Daughter. She admits she did not note the time of the incident on the progress note, nor did she document the time of the entry. She confirmed that she had never been interviewed by anyone in Administration or Corporate regarding the incident.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, interview and record review, the facility failed to adhere to the written grievance policy for receiving and responding to Resident complaints. The facility failed to demonstrate that such procedure was implemented upon receipt of the grievance, for 1 of 3 sampled residents reviewed (Specifically Resident # 1).

The findings included:

On a review of the facility Incident Log Report was conducted. The report dated revealed that Resident # 1 was discovered entering the main lobby, using her walker, from her right leg. The incident was documented at 06:30 PM. The incident report reveals that the Resident had left the building without Staff knowledge. The report does not indicate the amount of time the Resident had been outside of the building, nor the details of her elopement attempt.

Review of the Health Assessment form (form 1823), dated for Resident # 1, reveals the Resident suffers from , and a History of . She has limited ambulation and . Her cognition and behavioral status notes she is forgetful with . She also requires oversight. She uses a walker for ambulation assistance.

On at 10:15 AM, an interview was conducted with the facility Administrator. She stated that she did not have any grievances for the month of , when Resident # 1 had left the building and injured herself. Two hours later a copy of a grievance report dated was produced by the Corporate Executive Director. The facility Administrator stated that she was never aware that a

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grievance form had been completed by anyone. She stated she had been made aware that the Resident's daughter had called the next day and was ballistic about what happened to her mother, but she did not feel it warranted the completion of a grievance form.

On at 10:15 AM, the initial request for the incident investigation report was made for the incident, which occurred on . The Administrator nor the Executive Director did not provide a copy of the internal investigation that was conducted to determine whether the elopement or the was avoidable or unavoidable. On at 04:19 p.m., a final request for the documentation was made. The Surveyor was advised that their Corporate policy stated that this information was not to be provided to the State Agency. The surveyor was unable to determined what staff or residents were interviewed nor what documentation was used to determine outcome of the investigation due to the facility failure to provide requested documentation.

A review of the progress note dated /2017 states the Resident was outside of the building after her daughter's visit. The note stated the Resident sustained a to her right leg approximately 2 inches in length, that required treatment by the Nurse. The Nurse on duty stated she gave the Resident First Aid. She also notified the Resident's daughter and the Resident's Physician. The progress note does not include the time of the entry or the time of the incident.

A review of the facility Grievance policy # CL-SS-8017, date of origin , review date and approval date . States the community goal is to provide prompt investigation and resolution of all Complaints and Grievances. Incident date: and Grievance form dated: . The definition of Grievance in the policy states: It is a verbal or written complaint that cannot be resolved promptly by Staff present.

A review of the facility Elopement policy dated CL-INTER-201 Wandering and Elopement. States: Elopement - Attempt - when a Resident without supervision is exit seeking or attempts to leave the community/secured area, but does not cross the threshold of a secured area.

A review of the Grievance Report completed by the Corporate Executive, stated the facility determined the Resident did not outside. An interview with the Nurse on duty at the time of the incident stated she went outside and saw a trail of on the steps of the outside door. She says she concluded this is where Resident # 1 was injured. The Grievance report also indicates the facility determined the Resident was not outside for more than 15 minutes. Based on interviews with Direct Care Staff and the

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Concierge on the front desk at the time. No one was aware that the Resident had left the building, nor the extent of time she had been missing. The report stated that the Resident self-directed her return. In an interview with the Concierge on duty at the time, she stated a visitor noticed the Resident wandering in the parking lot and redirected her to the main entrance.

On at 02:30 PM, an interview was conducted with Resident # 1. She was asked how long she had been in the facility. She responded that she did not know. She stated she was there while her kids were in school and her husband was at work. She stated she did not know the name of the place, nor what she resided. She says she has kids, but she does not recall her daughters' name. She says her Son was outside playing. She pointed to the walker and indicated she has to use this "thing" to walk, but she did not know the name for it. She stated she did not recall leaving the building or hurting her leg.

On at 03:34 PM, an interview was conducted with the Concierge. She stated between 05:30 PM - 07:30 PM, a visitor in the parking lot helped Resident # 1 into the main entrance. The visitor stated he saw her wandering in the parking lot injured. She stated she noticed on her right leg and helped her enter the building. She stated she notified the Licensed Practical Nurse (LPN) on duty. She stated she was never interviewed by anyone in Administration or Corporate regarding the incident.

On at 03:35 PM, an interview was conducted with the Licensed Practical Nurse (LPN) on the 03:00 PM - 11:00 PM shift. She stated she was notified by the Concierge of the incident involving Resident # 1. She sated she helped her to her , cleaned her up, provided First Aid and put her to bed. She stated she made proper notifications to the Resident's Physician and Daughter. She admits she did not note the time of the incident on the progress note, nor did she document the time of the entry. She confirmed that she had never been interviewed by anyone in Administration or Corporate regarding the incident.

Based on the investigation, it was determined the facility failed to provide documentation of a complaint investigation. The details of the grievance report are not consistent with interviews from the Resident and facility Staff involved. The grievance form was not completed in a timely manner.

Class