PRINTED: 10/24/2014
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106027	A. BUILDING ______ B. WING ______	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT ORLANDO INC	2000 NORTH SEMORAN BOULEVARD ORLANDO, FL 32807

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F 000	INITIAL COMMENTS Recertification survey was conducted from to Avante at Orlando was not in compliance with 42 CFR Part 483 and 488, requirements for long term care facilities.	F 000	Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the items alleged or conclusion set forth in the statement of deficiencies. The plan of corrections prepared and / or executed solely because it is required by the provision of Federal and State laws.	
F 241 SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to treat a resident with with dignity and respect when the resident refused care for 1 of 31 sampled residents (#86). Due to this failure, the resident sustained psychosocial harm. Findings: (cross reference to F309, F282, F329) On at 11:07 a.m., resident #86 was heard yelling. The the resident's door was closed, but the resident could be heard from the common area outside her After a staff person in the permission to enter, observation revealed resident #86 was the only resident in the She was yelling, "get out." She was attempting to kick, bite, and hit 2 certified nursing assistants (CNAs), # C and #D. The resident continued to tell the CNAs to "get out of here," but they did not stop care and/or	F 241	F241 1. Immediate action(s) taken for the resident(s) found to have been affected include: a. On CNA #C and CNA #D were immediately removed from Resident #86 care and was suspended pending investigation. On investigation was completed and CNA#C and CNA #D were terminated. b. Resident #86 was immediately reassigned to a familiar staff member,	11/16/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 11/5/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

11/12/14 [illegible]

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F 241 Continued From page 1

step away from the resident. CNA #D was holding both of the resident's hands tightly and the resident was trying the break free of her grip. CNA #C was attempting to button the resident's shirt and the resident continued to yell and attempt to bite, kick, and hit the CNAs. They did not stop attempting to provide care despite the residents repeated requests for them to get out and the resident's attempts to kick, hit, and bite them. The resident was visibly distressed. Both CNAs began to laugh at the resident as she resident continued to try to bite them and kick them. When asked why they were continuing to ignore the resident's requests to stop, they said they continued because the resident was soiled with bowel movement and they had to clean her. They said she then would not let them dress her so they held her hands so she couldn't hit them.

Within a few minutes, the Unit Manager (UM) was informed and she entered the [redacted] The resident was visibly upset and was yelling and screaming as she was saying, "help me" and "get out of here." She was still trying to hit, bite, and kick the CNAs while they stood at the bedside. They did not attempt to speak to the resident in a calm and respectful manner even after the UM entered. At that time CNA #D said to the UM, "this resident is crazy" in the presence of the resident and the UM. The UM then asked both CNAs to leave the [redacted] she stayed with the resident.

In an interview with CNA #C and #D on [redacted] at 11:30 a.m., CNA #D said she was assigned to care for resident that day and she was familiar with resident #86 because she cares for her every day she works. She said the resident is not always resistant to care. When she entered the resident's [redacted] deliver care she said the

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was reassessed for comfort, and provided with care interventions. She accepted care with a continued calm demeanor.

c. Ongoing reassessment has included Medication Review by the Consultant Pharmacist, and attending Physician, Pain Assessment, and Behavioral monitoring to identify potential patterns and triggers. Hospice, the primary physician, affiliated consultants, family and primary care staff were involved in the review, revisions and updates to her individualized plan of care. She has resumed her usual preferred routines

d. Updates on resident specific preferences and interventions are being provided to primary staff through education, shift reports, and skill fair activities.

2. Identification of other residents having the potential to be affected was accomplished by:

(1) All residents with a diagnosis of [redacted] other

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F 241 Continued From page 2
resident told her to get out. She said she reported it to the nurse who instructed her to take another staff member with her to provide care. CNA #D said she did not want to leave the resident who was of BM at that time without cleaning her even though the resident was refusing care at that time. CNA #B said when a resident resists care we usually come back later, but we could not leave the resident soiled. When asked why they did not stop as the resident continued to refuse and became more and more agitated, they said, "we had to finish because we could not leave her that way."

During observation on at approximately 12:00 p.m., the resident was observed being taken out of her a wheeled recliner. The resident was calm and was not attempting to kick, hit or bite staff. At that time the UM said the resident was upset and continued to attempt to hit and kick her, but she eventually became calm because she did not attempt further care, watched the resident from a distance, and spoke to her in a calm voice. After she was calm, the UM said she was able to finish care.

In an interview withe the UM at at 12:55 p.m., she said she thought the both CNAs behavior was not acceptable. They did not treat the resident with dignity or respect. They should not laugh at resident's or call them names like "crazy." She thought the resident's agitation and distress could have been avoided had the CNAs not continued to provide care when the resident first expressed her wishes for them to get out. They should have not have started care against the resident's wishes and should not have continued when the resident became extremely upset. She said she thought what happened was

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and high risk behaviors were identified and reassessed by the IDT for management of their current physical, mental and psychosocial wellbeing. There were no others identified to have been affected by the alleged deficient practice

a. Pain re-assessment is ongoing for identified residents.

b. Observations are addressed in the morning clinical review.

c. A 100% audit of Care Pans/Kardex was completed for identified residents. Updates were added to individualized plans of care as indicated.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:

a. Inservice education programs were conducted separately with licensed and non-licensed staff by the Director of Nursing Services (DON)/designees. Topics include Resident Rights and Recognizing/Preventing completed on

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F 241	Continued From page 3 not acceptable and they should have done a better job caring for a resident with ... because they care for many residents with ... "That is the type of residents we care for." Record review revealed resident #86 was admitted to the facility on ... with a diagnosis of Alzheimer's ... Review of her minimum data set assessment dated ... revealed the resident exhibited physical behaviors (hitting, kicking, pushing, scratching, or grabbing) 1-3 times per week and rejected care 1-3 times per week. She requires ... with all ADLs and has severe ... Social Services notes dated ... indicated the resident is able to make needs known to staff.	F 241	b. Proper procedures for addressing resident preferences obtained from interview information were discussed. Altering care to accommodate resident choice were also addressed to assure the maintenance of resident dignity and respect. c. The Director of Nursing, ADON, and designated MDS/Unit Managers are conducting clinical rounds on "All about Me" Questionnaires to reaffirm choices and preferences. d. The Director of Nursing/Designee provided education to nursing staff on F309, F241 and F329 in a series of education to include : "Know Your Role" and ... and Sensitivity training on "Walk in the Shoes", ... (Need to show continued presentations on this and the Know Your Role) e. Pain Management training was completed by Hospice physician on ...	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure furniture and fixtures were clean and in good repair in 2 out of 2 wings (North and South Wings.) Findings: North Wing 1. On ... at 2:00 p.m. ... the privacy curtain for bed A had grayish stain on it. At 1:50 p.m. ... frame			

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F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure furniture and fixtures were clean and in good repair in 2 out of 2 wings (North and South Wings.) Findings: North Wing 1. On at 2:00 p.m. the privacy curtain for bed A had grayish stain on it. At 1:50 p.m., frame			

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F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure furniture and fixtures were clean and in good repair in 2 out of 2 wings (North and South Wings.) Findings: North Wing 1. On at 2:00 p.m. the privacy curtain for bed A had grayish stain on it. At 1:50 p.m. frame			

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F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure furniture and fixtures were clean and in good repair in 2 out of 2 wings (North and South Wings.) Findings: North Wing 1. On at 2:00 p.m. the privacy curtain for bed A had grayish stain on it. At 1:50 p.m. frame	F 253	**F 253 Housekeeping & Maintenance Services** The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. 1) The privacy curtain in have been removed/replace with clean or new curtains. Completed:	11/14/14

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F 253	Continued From page 4 inside the shared rusted; the baseboard below the window was coming off the wall. At 3:00 p.m. , the wall near the air conditioning unit was peeling. At 11:15 a.m. the was gouged and in need of painting; a cabinet under the sink located near residents' closet has peeling veneer exposing sharp edges that can catch clothes or skin. At about 11:15 a.m. , the was gouged and in need of painting. At 11:20 a.m. , the door was gouged and in need of painting; baseboards inside the separating from wall. At 11:25 a.m. , the doors were scuffed and in need of painting; baseboards were peeling off wall in the 2. On at about 11:00 a.m. 126B, a ceiling tile was broken leaving a hole above Bed B. At 11:15 a.m. , there were scratches and unfilled holes on the 3. On 12:20 p.m. North wing nurse station, veneer/ is peeling off in several areas around the nurse station. South Wing 4. On at about 3:00 p.m. the dry wall by the air conditioning (A/C) unit was peeling off. There was a trace of water leakage near the A/C unit. A baseboard by the residents' closet was peeling. 5. On at about 3:10 p.m. , paint coming off walls and cracks in wall around fixtures in the resident's At 3:00 p.m. , a night stand for Bed A was in disrepair, i.e. all 3 drawers were out of tracks and	F 253	The door frame in has been repaired and is free of rust and the baseboard has been repaired/ or replaced and is no longer coming off the wall. Completed: , the wall has been painted and is free of peeling. Completed: the has been painted/repaired/ or replaced. The veneer on the cabinet under the has been repaired/ or replaced. Completed: 136 and 134, have been painted and the baseboard in has been re-applied to the wall. Completed: has been repainted and baseboards have been re-applied to the Completed: ceiling tile has been replaced. Completed:	

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F 253	Continued From page 5 edge veneer was missing around the table top of the night stand. The the same , the resident's closet door was bent inward. 6. On at 12:25 p.m. South wing Nurse station. Veneer baseboards and around the counter are coming off exposing sharp edges that could be caught on clothes and/or skin. An activity cabinet under the television set has missing glass panel on the door. A facility environmental tour was conducted with the director of facility services on from 1:15 p.m. to 1:45 p.m. The above observations were discussed and verified with him during the tour.	F 253	holes in the door were filled and repainted. Completed: the wall has been repaired and baseboard re-applied. The AC unit has been checked and is in proper working condition with no leaking. Completed: , walls have been checked for cracking/repaired and painted. Completed: night stand has been replaced. Closet door has been repaired and is in proper working condition. Completed: The glass door under the Activity cabinet has been removed making cabinet into shelf. Completed: Both North and South wing nurses stations have been evaluated for best possible solution for repair. Bids have been received and a process has been selected to repair and improve the F253 cont.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; diagnosis and health conditions;			

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AVANTE AT ORLANDO INC	2000 NORTH SEMORAN BOULEVARD ORLANDO, FL 32807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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Dental and nutritional status;
Skin conditions;
Activity pursuit;
Medications;
Special treatments and procedures;
Discharge potential;
Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to assess for risk for 1 of 3 residents reviewed for out of 31 sampled residents (#79).

Findings:

Resident #79 was admitted to the facility on . He has diagnoses including but not limited to: abnormality of gait, history of , rosis,and history of His initial risk screen was completed on and he received a total score of 14, indicating high risk for . The instructions on the screen indicated it was to be completed after each .

Review of the record revealed the resident had on the following dates:

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current residents. An audit will be done on all new admissions.

(3) The MDS Coordinators and Unit Managers were educated that a assessment must be completed on admission, after each , quarterly and annually.

(4) The DON/Designee will audit assessment completion after each x 4 weeks and randomly thereafter. Any variances will be reported to the Quality Assurance Committee on a regular basis to ensure on-going compliance.

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F 272	Continued From page 7 and The risk screen was not completed after each Review of the policy and procedure for assessment indicated a risk assessment should be completed when a resident In an interview with unit manager (UM) on 4:20 p.m. she said she looked in the electronic medical record said a field was not set up in the computer for risk so it was not completed after each In an interview with the minimum data set (MDS) coordinator on at 10:39 a.m., she verified assessment not completed after each and no assessments were done after admission until yesterday,	F 272	F282	
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement the care plan for residents with for episodes of being combative during care, communication, and medication for one resident reviewed for with behaviors of 31 sampled residents (#86). Findings: (cross reference to F309, F329)	F 282	(1) Resident #86 was re-assessed by nursing on She has resumed her usual routines. A full medication review was conducted on resident#86 by the Consultant Pharmacist on . Resident #86 was seen by the Attending Physician and no changes were made to her medication. The Care plan and kardex for resident #86 were updated and reviewed by the Interdisciplinary Team. The caregivers of resident#86 were re-trained on her individualized care immediately. (2) All residents with a diagnosis of other and high risk behaviors	

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Record review revealed resident #86 was admitted to the facility on with a diagnosis of A care plan was initiated on and a history of , agitation, and . The goal is for the resident to maintain a stable mood and behaviors, will respond to redirection and re-approaches when resisting care. Interventions dated included: observe for things that could cause and restlessness, ask simple questions during care routines, observe for agitation during care-step away and re-approach if needed. An intervention was added on to offer words of encouragement, a listening ear, and utilize diversional activity if needed during episodes of crying. An intervention was added on to talk resident through each care routine, step away if needed if resident becomes combative.

Review of her minimum data set assessment dated revealed the resident exhibited physical behaviors such as hitting, kicking, pushing, scratching, or grabbing 1-3 times per week and rejected care 1-3 times per week. She requires with all ADLs and has severe . Social Services notes dated indicated the resident is able to make needs known to staff.

On at 11:07 a.m., resident #86 was heard yelling. The the resident's door was closed, but the resident could be heard from the common area outside her . After a staff person in the permission to enter, observation revealed resident #86 was the only

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were identified. A 100% audit of the care plans /kardex for the identified residents were conducted and all corrections were made on

(3) On Nursing staff was in-serviced on Know your resident, Know your Role, Walk in the Shoes, Know the Person, Quality of Life and Care, Challenging Behaviors, The Five Basic Goals of Care, Profound thoughts time to change. In-service on identifying residents with behaviors and potential resolutions was done. An In-service was done on on the use of medications and gradual dose reduction.

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F 282	Continued From page 9 resident in the . . . . She was yelling, "get out." She was attempting to kick, bite, and hit 2 certified nursing assistants (CNAs) # C and #D. The resident continued to tell the CNAs to "get out of here," but they did not step away from the resident. CNA #D was holding both of the resident's hands tightly and the resident was trying the break free of her grip. CNA #C was attempting to button the resident's shirt and the resident continued to yell and attempt to bite, kick, and hit the CNAs. They did not stop attempting to provide care despite the residents repeated requests for them to get out and the resident's continued attempts to kick, hit, and bite them. The resident was visibly distressed and continued to be combative. When asked why they were continuing to ignore the resident's requests to stop, they said they continued care because the resident was soiled with bowel movement and they had to clean her. They said she then would not let them dress her so they held her hands so she couldn't hit them. In an interview with CNA #C and #D on . . . . . . at 11:30 a.m., CNA #D said she was assigned to care for resident that day and she was familiar with resident #86. She said the resident is not always resistant to care. When she entered the resident's . . . . . . deliver care that morning, she said the resident told her to get out. She said the reported it to the nurse who instructed her to take another staff member with her to provide care. CNA #D said she did not want to leave the resident who was . . . . of BM at that time without cleaning her even though the resident was refusing care at that time. CNA #B said when a resident resists care we usually come back later, but we could not leave the resident	F 282	(4) The DON/Designee will monitor new and re-emerging behaviors through daily reports such as: Stop and Watch, SBAR(changed in condition) discussed in the morning meeting will be added to the white Board, Daily Kardex and Care Plans updates will be shared with line staff through shift huddles. Will audit for four weeks and then as needed. Variances will be reported to QA on a regular basis to ensure recommendations and /or suggestions for ongoing compliance.	

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soiled. When asked why they did not stop as the resident continued to refuse and became more and more agitated, they said, "we had to provide care because we could not leave her that way."

In an interview withe the UM at at 12:55 p.m., she said she thought the both CNAs behavior was not acceptable and they did not follow the plan of care for this resident. She thought the resident's agitation and distress could have been avoided had the CNAs not continued to provide care when the resident first expressed her wishes for them to get out. They should have followed any of the care plan interventions to step away from the resident.

Resident #86 had a care plan for communication problem related to diagnosis of . It was initiated on . The goal was for the resident to be able to make basic needs known on a daily basis. The interventions included but were not limited to: anticipate and meet needs, monitor/document for physical/nonverbal indicators of discomfort or distress.

In interviews on with LPN #B at 10:16 a.m., RN #F at 10:33 a.m., and the social service director at 11:50 a.m., they confirmed the resident had combative behavior when resisting care. They said the documentation of the behaviors should be in the nurses notes. Review of nurses notes revealed they did not include documentation or monitoring of physical or nonverbal indicators of distress occurring 1-3 times a week.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Resident #86 had a care plan for medication related to initiated on and revised on . The goal was for the resident to be free of discomfort or adverse reactions related to medications. One of the interventions was to administer the medication per the physician's order. Review of the physician's order dated revealed the resident was receiving 0.5 mg 3 times a day for agitation. The was listed on the medication record to be given at 6:00 a.m., 2:00 p.m., and 10:00 p.m. The target behavior on the behavior monthly flow record was listed as and hallucinations. The record indicated the resident was not exhibiting either behavior. On , a telephone order was documented for 0.5 mg for one dose for the same reason, agitation. However, the nurses notes documented the resident was given the medication on for refusing care by kicking, hitting, and spitting at staff. The resident received another order for 0.25 mg every 6 hours as needed(PRN)for agitation on . The order did not include any other target behaviors. From to the resident received the PRN medication 8 times. The reason for giving the medication was documented in the nurses notes as being combative with staff, or restlessness on 3 of those times. The other times agitation was listed, but the description of the resident's agitation was not documented.

In an interview with RN #F on 10:33 a.m., he said he will give the PRN when the CNAs tell him the resident is agitated when they want to give care. He said he did not does see combative behavior because she is usually calm with him. In an interview with LPN #B on

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F 282	Continued From page 12 10:16 a.m. she said the resident gets combative when she gets bothered. She said the resident had that behavior approximately 1-3 times a week. She said if the resident is agitated when the CNAs want to give care, they tell her so she can administer the PRN	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide care in a manner to promote the highest practicable mental, psychosocial, and physical well being for a resident with who resisted care that resulted in substantial distress and physical injury for 1 of 1 resident reviewed out of 31 sampled residents (#86). Findings: (cross reference to F241, F282, F329, F498) Record review revealed resident #86 was admitted to the facility on with diagnoses including, but not limited to, and adult . The current minimum	F 309	F309 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 86. Immediate Corrective Actions: a. CNAs #C and # D were immediately suspended, investigation completed and both employees were terminated. b. The nurse, employee # B was immediately suspended pending investigation and reinstated following completion of the investigation. The nurse employee is currently participating in ongoing education regarding assessment and response to residents with behaviors.	11/16/14

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F 309	Continued From page 13 data set (MDS) assessment dated indicated the resident had severe She is usually understood and can express her needs. She has no hallucinations or She exhibits physical behavioral symptoms directed towards others such as, hitting, kicking, pushing, scratching 1-3 days a week. She rejects care 1-3 days a week. The resident is always of and frequently of bowel. She requires with activities of daily living. On at 11:07 a.m., resident #86 was heard yelling. The the resident's door was closed, but the resident could be heard from the common area outside her After a staff person in the permission to enter, observation revealed resident #86 was the only resident in the She was yelling, "get out." She was attempting to kick, bite, and hit 2 certified nursing assistants (CNAs) # C and #D. The resident continued to tell the CNAs to "get out of here," but they did not stop care and/or step away. CNA #D was holding both of the resident's hands tightly and the resident was trying the break free of her grip. CNA #C was attempting to button the resident's shirt and the resident continued to yell and made repeated attempts to bite, kick, and hit the CNAs. Neither CNA #D, nor CNA #C stopped attempting to provide care despite the resident's repeated requests for them to get out and the resident's continued attempts to kick, hit, and bite them. The resident was visibly distressed. Both CNAs began to laugh at the resident as she resident continued to try to bite them and kick them. When asked why they continued to ignore the resident's requests to stop, they said they	F 309	c. Resident # 86 was immediately re assessed by the IDT for management of her current physical, mental and psychosocial wellbeing. Behavioral Observation was done to attempt to identify potential patterns and triggers; Pain re-assessment conducted, and medication review was conducted by the Pharmacist in conjunction with the IDT. d. Hospice, the primary physician, psychiatrist, affiliated consultants, family, and primary care staff were involved in the review, revision, and updates to her individualized plan of care. She has resumed her usual preferred routines. 2. Those Potentially Affected by the alleged deficient practice as noted within F309: a. All residents with a diagnosis of other and high risk behaviors were identified.	

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continued because the resident was soiled with bowel movement and they had to clean her. They said she then would not let them dress her, so they held her hands so she couldn't hit them.

Within a few minutes, the Unit Manager (UM) was informed of the observation and she entered the . The resident was visibly upset and was yelling and screaming as she was saying, "help me" and "get out of here." She was still trying to hit, bite, and kick the CNAs while they stood at the bedside. They did not attempt to speak to the resident in a calm and respectful manner. At that time CNA #D said to the UM, "this resident is crazy" in the presence of the resident and the UM. The UM then asked both CNAs to leave the she stayed with the resident.

Later the same day, at 11:20 A.M. licensed practical nurse (LPN) #B was observed preparing medication and walked into resident #86's When she exited the said it was 0.25 milligrams (mg) and it was ordered as needed (PRN) for agitation. She said the resident would not take it so she was going to call the physician to ask for an medication to be given via an injection.

In an interview with CNA #C and #D on at 11:30 a.m., CNA #D said she was assigned to care for resident today and she was familiar with resident #86. She said the resident is not always resistant to care, it depends on her mood. When she entered the resident's deliver care she said the resident told her to get out. She said she reported it to the nurse who instructed her to take another staff member with her to provide

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b. Identified Residents were re assessed by the IDT for management of their current physical, mental and psychosocial wellbeing with carè plan updates as indicated. There were no others noted to have been affected by the alleged deficient practice.

c. Pain re-assessment is ongoing on designated residents with haviors/psych to rule out pain as a causative factor. Medication reviews were conducted for designated residents by the Pharmacist in conjunction with the IDT.

d. Behavioral Monitoring is ongoing on designated residents with a known hx of behaviors affecting others, or refusals of care to identify potential patterns and triggers

e. A 100% audit of the Care Plans/Kardex for the identified residents was conducted and corrections were made on

f. Updates to care plans and Kardexes were provided through education, shift reports, and skills fair activities.

g. Residents will be discussed as indicated at Daily Ops and Clinical

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care. CNA #D said she did not want to leave the resident who was : of BM at that time without cleaning her even though the resident was refusing care at that time. CNA #B said "when a resident resists care we usually come back later, but we could not leave the resident soiled." When asked why they did not stop and step away as the resident continued to refuse and became more and more agitated, they said, "we had to finish because we could not leave her that way. What else were we supposed to do? We couldn't let her hit us."

During an observation on at 12 p.m., the resident was observed being taken out of her a wheeled recliner chair. At that time, the UM said the resident was upset and continued to kick and swing at her for the next 40-45 minutes. During that time, she said she stayed in the the resident to observe her, but out of her reach and spoke to the resident in a calm manner. She said the resident refused the pill, so she instructed the nurse to call the physician to ask for a medication that could be given via injection. The UM said the resident eventually became calmer and agreed to finished getting dressed and transfer to the chair with staff assist. The physician ordered 0.5 mg one time for agitation, but the UM said they did not need to give it because she was able to help the resident become calmer and allow care.

On at 12:40 p.m., the resident was observed being taken away from the lunch table by CNA #E. "Refused" was marked on her meal ticket. The resident was calm and was not yelling, kicking or hitting. In an interview with CNA #E at that time she said resident would not

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Quality Reviews, Weekly QOL meetings, and as part of daily, weekly, and monthly QAA/QAPI activities.

3. System Changes and Measures were put into place to ensure that the alleged deficient practice does not recur includes:

a. Director of nursing/designees provided education to nursing staff on F309, F241, and F329 "Know Your Role" (1 and

b. Pain Management training by Hospice physician on

c. "Walk in the Shoes" of the resident Training on with continuation during

d. The Hand in Hand Series was conducted for sessions 1-4 on the following dates: – Module 1; – Module 2; – Modules 3 &4.

e. Director of Nursing, ADON, and IDT Members provided all day skills training on and 5th. Topics included: Hand in Hand Reinforcement, Stop and Watch, and SBAR reporting, Food Handling, and Control, survey competencies.

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eat. She said she has cared for the resident before and depending on the resident's mood she will feed herself, let staff assist, or refuse.

In an interview withe the UM at at 12:55 p.m., she said she thought the both CNAs behavior was not acceptable. They did not treat the resident with dignity or respect. She thought the resident's distress could have been avoided had the CNAs not continued to provide care when the resident first expressed her wishes for them to get out. They should have not have started care against the residents wishes and should not have continued when the resident became extremely upset. She said she thought what happened to the resident was not acceptable and they should have done a better job caring for a resident with because they care for many residents with "That is the type of residents we care for."

Review of the facility assignments and revealed CNA #D was the CNA who cared for the resident every day she worked for 8 shifts in and 22 shifts in CNA #C worked 19 shifts in and 11 shifts on The facility had consistent assignments.

On 3:55 p.m. the resident was observed in TV area in the recliner chair across from her She was listening to the music program and alternatively closing eyes. The first knuckle on the back of her right hand was red and On at 10:15 a.m. the resident was observed in bed eyes with her eyes closed. After a knock on the door, she opened eyes and spoke calmly. The first knuckle on the back of the right hand was red, , and had a purple

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f. The Director of Nursing, ADON, and designated MDS/Unit Managers are conducting clinical rounds using the All About Me tool to reaffirm resident choices and preferences.

g. The Use of Therapeutic Activities at the bedside and types of activities developed specific to those with was provided by external Activities consultants on 11/5 and

h. External Activities Consultant providing on site visits for next 4 weeks to further develop person centered programming with "All About Me" data.

i. Education on bedside and on unit activities for C.N.A. staff was provided on

j. Hand in Hand Training will be included in ongoing orientation and staff education offerings.

4. How the corrective action(s) will be monitored to ensure the practice will not recur:

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area extending towards her fingers. The knuckle on the right hand middle finger was red. The resident smiled and moved her right hand freely.

In an interview with the UM on at 10:30 a.m., she said the resident initially complained of pain in her right hand on and said "they hurt me" as she pointed to her right hand. She said the physician was notified and an X ray was obtained. It was negative for of the hand and showed . The UM said the resident became calm after she stepped away from the bedside and spoke to her in a calm manner.

In an interview with the hospice CNA caring for the resident on at 12:19 p.m., she said she is aware the resident can be combative with care, but she said it depends how you approach the resident. She said if the resident says no and/or attempts to swing at her, she steps away and tells the nurse that the resident refused care at that time. She said usually she can go back and sit with the resident and hold her hand, she will not become combative or agitated, and she will agree to care. She said she often works with another hospice CNA, but they provide care in small steps and explain each step of care along the way.

The social services director was interviewed on at 10:50 a.m. regarding how she determines what to document on the MDS assessment regarding resident #86's behavior. She said she documents in her social service progress notes what she retrieves from nurses notes, hospice notes, and CNA interviews. She said her behavior is calm when she is in the recliner chair out in atrium. She said it depends

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a. Will conduct a random care audit of (2) residents identified with Alzheimer's or related with the potential for behavioral manifestations weekly for four (4) consecutive weeks

b. DON/Designee will conduct a random audit of two (2) residents receiving Pain Management a minimum of 3 times weekly for 3 months.

c. The Adm/Activity staff or designee will perform on unit rounds a minimum of 3 x weekly for 3 months to ensure comfort care alternatives are in place and working effectively

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F 309	Continued From page 18 on her mood on whether or not she allows care. The quarterly review notes dated indicated the resident has episodes of crying and restlessness at times and she also becomes combative with ADL care and will attempt to kick and scratch caregivers. The notes did not address any attempt to determine why the resident exhibits the behaviors or that the resident received orders for PRN in addition to routine for increased agitation after the resident refused care on Review of the record revealed the physician's progress note dated noted nursing staff report increased agitation. Nurses notes documented the resident refused care and was kicking, hitting, and spitting. The physician wrote an order dated to receive 0.25 mg every 6 hours related to and agitation. Review of the medication administration record (MAR) revealed the resident received the PRN in addition to the routine on 8 occasions from to The nurse, LPN #B, attempted to give the again on for refusing care and being combative with staff and when the resident refused, she planned to get an order to give her an injection. A care plan was initiated on for and a history of agitation, and The care plan included interventions to: observe for agitation during care-step away and re-approach if needed. On the interventions was added to talk resident through each care routine, step away if needed if resident becomes combative. The care plan did not include interventions to give the resident PRN when she became combative, although staff interviews and	F 309	d. The DON/designee will audit for the Use of the Stop and Watch System and Shift Huddles weekly x 3 for 4 weeks and then ongoing as part of the facility QAA e. Quality reporting systems will be used to evaluate Casper QM data, Pain and use, and related indicators and to develop or enhance PIP's as indicated. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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F 309 Continued From page 19
documentation revealed the resident was given the medication for refusing care.

In an interview with RN #F on 10:33 a.m., he said he will give the PRN when the CNAs tell him the resident is agitated when they want to give care. He said he did not does see combative behavior because she is usually calm with him. In an interview with LPN #B on 10:16 a.m. she said the resident gets combative when she gets bothered. She said the resident had the behavior approximately 1-3 times a week. She said if the resident is agitated when the CNAs want to give care, they tell her so she can administer the PRN

On at 3:55 p.m. the director of nursing was asked to provide any policies or procedures for care of residents with and behaviors. On she provided a policy for and neglect. The policy referred to a catastrophic reaction as an extraordinary reaction of residents to ordinary stimuli, such as the attempt to provide care. The heading of "identification, correction and intervention in ıeglectful situations " included: deployment of staff to meet the needs of the residents and assure staff have the knowledge of the individual residents' care needs; supervision of staff to identify inappropriate behaviors; assessment, care planning, and monitoring of resident with needs and behaviors with might lead to conflict or neglect, such as residents with aggressive behaviors. The facility Clinical Protocol for Problematic Behavior Management included: identify individuals with cognition , document details about behavior such as onset, frequency, and precipitation factors, document features of any

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F 309	Continued From page 20 changes over time, staff will use protocols to identify pertinent interventions, other than medications, for the nature and causes of the individual's behavior. The policy for Behavior Assessment and Monitoring indicated the facility will comply with regulatory requirements related to the use of medications to manage problematic behavior. The "monitoring" section of the policy indicated staff will document in progress notes or behavior assessment forms the following information: number and frequency of episodes, preceding or precipitating factors, interventions attempted, and outcomes associated with interventions. During a meeting with the Administrator, DON, UM for 200 wing, and acting ADON/Independent Nurse Consultant for all Avante buildings on 10:30 a.m., the events of the previous day involving resident #86 were discussed. They all confirmed the manner in which the resident was cared for was not acceptable and the resident sustained avoidable substantial distress. At that time the education for care of residents with exhibiting resistance to care was discussed. Although the DON and acting DON described training in progress, they indicated the UM completes random observations of care and they had no formal process to observe care of CNAs/nurses and document findings. They had not provided the free Centers for Medicare and Medicaid Services training for Person-Centered Care of Persons with and Prevention of to their staff.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329	**F329** (1) On resident#86 was re-assessed by the nurse. Resident was stable and medication was not administered. Medication was discontinued immediately. On a full medication review was done by the Consultant Pharmacist. Resident #86 was seen by the	11/16/14

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F 329 Continued From page 21
unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate ; or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used drugs are not given these drugs unless drug is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to keep the drug regimen free of unnecessary medications for 1 of 6 residents reviewed for unnecessary medications of 31 sampled residents (#86).

Findings:

Resident #86 was admitted to the facility on with diagnoses including but not limited to: , and adult . Review of the

F 329
Attending Physician and her medical condition was stable, and there was no need for medication changes.

2) Ongoing audits will continue to discontinue medications which have not been used in the past thirty days with physician's orders. An in-service is scheduled for and by OPTUM on how to utilize non-pharmacological intervention for behavioral and residents.

(3) Nursing staff were in-serviced on the following: unnecessary medication, medications and gradual dose reduction, Medication Pending Report, Medication Cart Audit, Medication exception report, and 24 hour chart check. The Pharmacist or DON/Designee will conduct weekly audits x 4 and randomly thereafter to ensure that there is no unnecessary medications.

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F 329	Continued From page 22 physicians orders revealed the resident was receiving 0.5 milligrams (mg)3 times a day for agitation on . The target behaviors listed on the behavior/intervention flow record listed the target behaviors as and hallucinations. Specific agitated behaviors were not listed. The behavior flow records for and indicate the resident had no or hallucinations. The form included a section such as redirect, one on one, change position for interventions and it listed "medication-should not be first intervention." On nurses notes indicated the resident was very agitated and refused for staff to give care. The resident was kicking, hitting, and spitting at staff. A new order was received for 0.5 mg now. Another order was received on for 0.25 mg every 6 hours for agitation. The physicians note indicated nursing staff reports increased agitation and it was most likely due to will rule out process. The only behavior documented in the nursing notes for was when the resident became combative with care on and . The social service notes documented the resident becomes combative with ADL care and will attempt to kick and scratch caregivers. The documentation did not include any attempts at identifying the cause of the behavior or any non pharmacological approaches. Resident #86 had a care plan for medication related to initiated on and revised on . The goal was for the resident to be free of discomfort or adverse reactions related to medications. One of the interventions was to administer the medication per the physician's order.	F 329	(4) The Director of Nursing /Designee will present the results to the Quality Assurance Committee on a regular basis for recommendations and/or suggestions and to ensure ongoing compliance.	

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F 329	Continued From page 23 The care plan did not include any listing of non pharmacological interventions. On at 11:07 a.m., resident #86 was heard yelling. An observation at that time revealed she was in her she was yelling, "get out." She was attempting to kick, bite, and hit 2 certified nursing assistants (CNAs) # C and #D. The resident continued to tell the CNAs to "get out of here," but they did not stop care and/or step away. CNA #D was holding both of the resident's hands tightly and the resident was trying the break free of her grip. CNA #C was attempting to button the resident's shirt and the resident continued to yell and made repeated attempts to bite, kick, and hit the CNAs. Neither CNA #D, nor CNA #C stopped attempting to provide care despite the resident's repeated requests for them to get out and the resident's continued attempts to kick, hit, and bite them. The resident was visibly distressed. Both CNAs began to laugh at the resident as she resident continued to try to bite them and kick them. When asked why they continued to ignore the resident's requests to stop, they said they continued because the resident was soiled with bowel movement and they had to clean her. They said she then would not let them dress her, so they held her hands so she couldn't hit them. At 11:20 A.M. licensed practical nurse (LPN) #B was observed preparing medication and walked into resident #86's When she exited the said it was 0.25 milligrams (mg) and it was ordered as needed (PRN) for agitation. She said the resident would not take it so she was going to call the physician to ask for an medication to be given via an injection.	F 329	Page intentionally left blank.	

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F 329	Continued From page 24 Review of the medication administration sheet revealed the resident received the extra doses of 9 times from to RN #B gave the PRN 4 of the 9 times and LPN #B gave the PRN 2 of the 9 times and attempted an additional time on In an interview with RN #F on 10:33 a.m., he said he will give the PRN when the CNAs tell him the resident is agitated when they want to give care. He said he did not does see combative behavior because she is usually calm with him. In an interview with LPN #B on 10:16 a.m. she said the resident gets combative when she gets bothered. She said the resident had that behavior approximately 1-3 times a week. She said if the resident is agitated when they want to give care, they tell her so she can administer the PRN Review of nurses notes revealed the specific behaviors exhibited that resulted in the resident receiving the extra doses of were only documented as either agitation, or restlessness, although the behavior that precipitated the order for the extra dose of was refusing care on Non pharmacological interventions or other behavioral interventions were not documented.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	F 332 (1) Resident # 56 had no negative outcome. Attending Physician, POA and Medical Director were notified. (2) No other residents were identified as affected by the alleged deficient practice. A 100% audit of medication carts to MARS and physician order sheets was completed with no other issues identified.	11/16/14

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F 332 Continued From page 25

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure it was free of medication error rates 5 percent or greater. The facility had 2 medication errors out of 26 opportunities. The medication error rate was 7.69% (#56).

Findings:

The medication administration observation task was conducted on at 9:39 AM with RN #A. When the nurse was finished preparing the medications for resident #56, she verified she had 10 separate pills in the medication cup. She administered the medications to the resident. Review of the physicians' orders revealed the nurse made two medication errors. The order for was 8.6 milligrams (mg) 2 tabs daily. The nurse administered one pill, not 2 as ordered. The resident had orders for 75 mg daily. The medication record indicated the was to be given at 9 AM. The nurse did not administer the as ordered. The errors were reviewed with RN #A on 9:16 a.m. and confirmed she only gave 10 pills and should have given 12 pills.

F 371 SS=D 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

F 332

(3) Licensed nurses were re-educated on medication Administration, preventing medication errors, medication availability, pharmacy services, and the use of medication exception report.

1. On a repeat 100% audit is scheduled in conjunction with pharmacy review.
2. On a representative from Pharmacy conducted in-service on medication administration and med pass with nursing staff.

(4) Director of Nurses/Designee to the complete random MAR and chart audits weekly for the next 4 weeks. Director of Nursing/Designee will review the audits and submit the findings to the QAA/QAPI for recommendations and/or suggestions to ensure ongoing compliance.

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F 371	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to serve food in a sanitary manner for 2 residents on the north unit observed during dining observation. Findings: An observation was conducted of the lunch meal in the north atrium on at 12:35 PM. Staff #H was observed to remove a roll out of the plastic covering with her bare hands. She then proceeded to slice the roll while handling the roll in her hands. She then buttered the roll while holding the roll with her bare hands. She then placed the roll on the plate of resident #72. She then proceeded to another table and did the same for resident # 93. An interview was conducted with staff #H at 12:40 PM on She verified that she handled the rolls with her bare hands and said that was what she was taught.	F 371	F371 (1) CNA#1 was in-serviced on proper handling techniques for meal services. (2) No other residents were identified (3) Nursing/Dietary staff were in-serviced on using proper handling techniques such as: Preventing the eating surfaces of plate from coming in contact with staff clothing, handling cups/glasses on the outside of the container, and handling knives, forks and spoons by the handles. (4) Dietary Manager/Director of Nursing/Designee will observe whether staff used proper hygiene practices such as: keeping their hands away from their hair, face and also do not use bare hands to handle food. Dietary manager/Director of Nursing/Designee will complete audit randomly during breakfast, lunch and dinner to ensure that the proper handling of meals. The Dietary Manager/Designee will review audits and submit the findings to the QA Committee on a regular basis for recommendation and/or suggestion to ensure ongoing compliance.	11/16/14
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general			

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F 425	Continued From page 27 supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility did not ensure pharmaceutical services provided ordered medication in a timely manner for 1 of 1 residents observed during medication administration (#56) Findings: During the medication administration observation task on at 9:39 AM with RN #A, she was observed pour a pill, Vesicare, from a plastic card that was taken from a box. She said it was a sample from the physicians office and she was using the samples until the medication was delivered from the pharmacy. She said she did not know when the medication was expected to arrive from the pharmacy. The sample boxes were not labeled with the resident name or dose. Review of the record revealed a physician's order dated 10/0... for Vesicare 10 milligrams once a	F 425	F425 (1) On Pharmacy was notified of a missing medication for Resident #56. Medication was obtained immediately. (2) No other residents were identified with missing medications. (3) Licensed Nurses were re-educated on Missing medications , medication Pending Report, Medication Exception Report, 24 Chart Check and the ordering of medications through Pharmacy in a timely manner. On Pharmacy in-serviced the licensed nurses on various topics such as: "Never accept sample medications," " All medications must have a prescription label "and "prescriptions must be dispensed through a pharmacy". Pharmacy conducted MAR to Cart Review on and will be ongoing.	11/16/14

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F 425	Continued From page 28 day. During an interview with the unit manager (UM) on at 4:40 p.m., she said the Vesicare will arrive today. When asked when it should have arrived, she said the day after it was ordered. She said she spoke with the pharmacy and they informed her they did not receive the faxed order on The policy and procedure for medication ordering and receiving from pharmacy indicates medications are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. In the section for receiving medications from pharmacy it lists: the nurse promptly reports discrepancies and omission to the issuing pharmacy and the charge nurse/supervisor. The UM then stated she did not have a record of when the order was faxed. she said the facility should not be using the sample medication that was not supplied by the pharmacy that had no label. The nurses should have checked with the pharmacy to see when the medication was expected to arrive, and not continue to use the samples without asking.	F 425	(4) Director of Nursing and Unit Managers will complete random audits throughout each shift for 4 weeks to validate that there is no missing medications, and that medications will be ordered through pharmacy in a timely manner. The Director of Nursing/Designee will review the audits and submit the findings to the QA Committee Members monthly. The QA Committee will determine whether there is need for additional auditing and if further education or revision to the plan is needed.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431	**F 431** (1) RN # A was in-serviced on Medication Administration and medications labels. Pharmacy was notified and medication was obtained. 2) No other residents had medication with missing labels	11/16/14

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F 431	Continued From page 29 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Prevention and Control Act of 1976 and other drugs subject to , except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure medications were labeled appropriately for 1 of 1 residents observed during medication administration (#56) Findings: Two boxes of medication, Vesicare, were observed during the medication administration observation task on at 9:39 AM with RN #A. The nurse administered the medication taken from the box. She verified the boxes had no labels. She said she thought they were	F 431	(3) Licensed nurses were in-serviced on medication administration; the ordering/receiving medication from the Pharmacy; the appropriate components pharmacy labeling on (4) Director of Nursing and Unit Manager will complete random audits throughout each shift for 4 weeks to validate that there is no missing medication labels. The Director of Nursing/Designee will review and the audits and submit the findings to the QA Committee Members monthly. The QA Committee will determine whether there is need for additional auditing and further education is needed.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106027	A. BUILDING ______ B. WING ______	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 30 samples from the urologist. In an interview with the unit manager on at 4:40 p.m., she confirmed the medication samples should not have been used without a label. Review of the facility policy and procedure for medication labels read, only the pharmacy/registered pharmacist and modify, change, or attach prescription labels. The procedure included all the information needed on a label. Medications dispensed by physicians must conform to labeling requirements.	F 431		
F 441 SS=D	483.65 CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of and (a) Control Program The facility must establish an Control Program under which it - (1) Investigates, controls, and prevents in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to (b) Preventing Spread of (1) When the Control Program determines that a resident needs isolation to prevent the spread of , the facility must the resident. (2) The facility must prohibit employees with a communicable or skin	F 441	F 441 (1) Staff #1 and Staff #G were in-serviced on on the appropriate product and procedure used to clean and glucose meters. (2) No other residents were identified (3) On Nursing staff were in-serviced on the appropriate product (PDI Sani wipes) and the procedure used to clean glucose meters. On a representative from Arkray inserviced the Licensed Nurses on the appropriate product and procedure used to clean and glucose meters.	11/16/14

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F 441	Continued From page 31 from direct contact with residents or their food, if direct contact will transmit the (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to sanitize and accurately explain the procedure to sanitize contaminated reusable equipment on 1 of 2 wings (north wing.) Findings: During a medication pass observation on at 4:10 PM, staff # I was observed cleaning a glucose meter with an wipe. She then proceeded to do glucose fingerstick on resident #49. She then came back to the medication cart and wiped the glucose meter with an wipe and put the meter back in the cart. An interview was conducted with staff #I on at 4:15 PM. She stated she uses wipes to clean the glucose meters because the sani wipes are too harsh on her hands. An interview was conducted with staff #G on at 10:17 AM. When asked what she	F 441	4) The Director of Nursing/Designee will complete audit throughout each shift for the next four weeks to ensure that staff know and demonstrate the appropriate product and procedure used to clean and glucose meters. The Director of Nursing/Designee will review audits and submit the findings to the QA Committee for the next four weeks. The QA Committee will determine whether there is a need for additional audits and further education.	

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F 441	Continued From page 32 uses to clean the glucose meters, she replied that she uses hand sani-wipes and showed the container of hand sanitizer wipes, a product used to clean hands. An interview was conducted with the director of nursing on at 11:30 AM. She stated that the facility policy was to clean the glucose meters with sani-wipes, a bleach based product. A review of the facility policy read same.	F 441		11/16/14
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensue that nurse aides are able to demonstrate competency in skills and techniques necessary to care for the needs of residents with and resisting care, and as described in the plan of care for 1 of 1 resident reviewed of 31 sampled residents (#86). Findings: (cross reference to F241, F282, F309) On at 11:07 a.m. 2 certified nursing assistants (CNAs)#C and #D were observed treating resident #86 in an undignified manner. They were laughing at her and said she was "crazy." The resident was refusing care and she	F 498	**F498** 1) On CNA #C and CNA #D were removed from providing care to Resident #86 and was suspended immediately. On CNA#C and CNA#D were terminated after a complete investigation. 2) No other residents were identified 3) Nursing Aides were educated on various topics which identified the appropriate skills and techniques used when caring for residents with other and high risk behavior. The topics included “Bathing without a Battle”, Mouth care without a Battle”, “Hand in Hand”, “Walk in the Shoe”, and “COLA” Nurses' Aides were educated on kardex use.	

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F 498	Continued From page 33 was yelling, attempting to kick and bite, so they were holding her hands so she would not swing at them. As the resident became more agitated and continued to refuse care, they did not step away and/or speak to the resident in a calm manner per the plan of care. Review of both CNA's education revealed they had received training upon hire for and had participated in annual training for resident behavior, and resident rights. The content of the training did not address how to handle situations in which a resident with refuses care. The facility had not provided the free training offered in 2013 by Centers for Medicare and Medicaid Services for Person-Centered Care of Persons with and Prevention of to their staff. The DON said she had the material, but it had not been presented to staff. In an interview with the director on nursing DON, the interim assistant ADON/independent nurse consultant, and the unit manager for the unit in which resident #86 resides, on at 10:30 a.m., they agreed there are no circumstances in which a resident should be forced to receive care against their wishes and should not be held against her wishes. The content of the training provided to staff did not include any scenarios such as the one that involved 2 CNAs and resident #86. During the interview, the UM and DON stated they had no formal process to observe the competencies of the CNAs for any training received. The UM said she completes random checks on residents, but she could not provide any documentation or any evidence of monitoring CNA competency for care of resident	F 498	4) There will be direct care observations of Nurses' Aides by Staff Nurses, Unit Managers, DON/Designee throughout each shift. This will be conducted through Rounds, CNAs report changes through Stop and Watch and through the shift Huddle Reports. Random audit will be conducted three times a week for 12 weeks to validate the competency of Nurses' Aides. The DON/Designee will review and submit findings to the QA Committee on a regular basis for recommendations and /or suggestions to ensure ongoing compliance.	

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F 498	Continued From page 34 with	F 498	Page intentionally left blank.	

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N 000	INITIAL COMMENTS A Relicensure survey was conducted from to . Avante at Orlando had deficiencies at the time of visit.	N 000	Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the items alleged or conclusion set forth in the statement of deficiencies. The plan of corrections prepared and / or executed solely because it is required by the provision of Federal and State laws.	
N 054 SS=D	59A-4.107(5), FAC Follow Physician Orders All physician orders shall be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record during that shift. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure it was free of medication error rates 5 percent or greater. The facility had 2 medication errors out of 26 opportunities. The medication error rate was 7.69% (#56). Findings: The medication administration observation task was conducted on at 9:39 AM with RN #A. When the nurse was finished preparing the medications for resident #56, she verified she had 10 separate pills in the medication cup. She administered the medications to the resident. Review of the physicians' orders revealed the nurse made two medication errors. The order for was 8.6 milligrams (mg) 2 tabs daily. The nurse administered one pill, not 2 as ordered. The resident had orders for 75 mg daily. The medication record indicated the was to be given at 9 AM. The nurse did not administer the Plavix as ordered. The errors	N 054	**N054** (1) Resident # 56 had no negative outcome. Attending Physician, POA and Medical Director were notified. (2) No other residents were identified as affected by the alleged deficient practice. A 100% audit of medication carts to MARS and physician order sheets was completed with no other issues identified.	11/16/14

NOV 17 2014

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Executive Director | (X6) DATE 11/5/14

Agency for Health Care Administration

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N 054	Continued From page 1 were reviewed with RN #A on 9:16 a.m. and confirmed she only gave 10 pills and should have given 12 pills. Class III	N 054	(3) Licensed nurses were re-educated on medication Administration, preventing medication errors, medication availability, pharmacy services, and the use of medication exception report. 1. On a repeat 100% audit is scheduled in conjunction with pharmacy review. 2. On a representative from Pharmacy conducted in-service on medication administration and med pass with nursing staff. (4) Director of Nurses/Designee to the complete random MAR and chart audits weekly for the next 4 weeks. Director of Nursing/Designee will review the audits and submit the findings to the QAA/QAPI for recommendations and/or suggestions to ensure ongoing compliance.	
N 071 SS=D	59A-4.109(1), FAC Components of Care Plan Each resident admitted to the nursing home facility shall have a plan of care. The plan of care shall consist of: (a) Physician's orders, diagnosis medical history, physical exam and rehabilitative or restorative potential. (b) A preliminary nursing evaluation with physician's orders for immediate care, completed on admission. (c) A complete, comprehensive, accurate and reproducible assessment of each resident's functional capacity which is standardized in the facility, and is completed within 14 days of the resident's admission to the facility and every twelve months, thereafter. The assessment shall be: 1. Reviewed no less than once every 3 months, 2. Reviewed promptly after a significant change in the resident's physical or mental condition, 3. Revised as appropriate to assure the continued accuracy of the assessment. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to assess for risk for 1 of 3 residents reviewed for out of 31 sampled residents (#79).			

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N 071	Continued From page 2 Findings: Resident #79 was admitted to the facility on He has diagnoses including but not limited to: abnormality of gait, history of rosis,and history of His initial risk screen was completed on and he received a total score of 14, indicating high risk for The instructions on the screen indicated it was to be completed after each Review of the record revealed the resident had on the following dates: , and The risk screen was not completed after each Review of the policy and procedure for assessment indicated a risk assessment should be completed when a resident In an interview with unit manager (UM) on 4:20 p.m. she said she looked in the electronic medical record said a field was not set up in the computer for risk so it was not completed after each In an interview with the minimum data set (MDS) coordinator on at 10:39 a.m., she verified assessments were not completed after each and no assessments were done after admission until yesterday, Class III	N 071	**N 071** (1) On Resident#79 assessment was completed. (2) A 100 % audit on assessments will be completed by on all current residents. An audit will be done on all new admissions. (3) The MDS Coordinators and Unit Managers were educated that a assessment must be completed on admission, after each quarterly and annually. (4) The DON/Designee will audit assessment completion after each x 4 weeks and randomly thereafter. Any variances will be reported to the Quality Assurance Committee on a regular basis to ensure on-going compliance.	11/16/14
N 090 SS=D	59A-4.112(1), FAC Pharmacy Policies and Procedures The facility shall adopt procedures that assure	N 090	**N 090** (1) On Pharmacy was notified of a missing medication for Resident #56. Medication was obtained immediately. (2) No other residents were identified with missing medications.	11/16/14

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N 090	Continued From page 3	N 090		

the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident.

This Statute or Rule is not met as evidenced by:
Based on observation and interview the facility did not ensure pharmaceutical services provided ordered medication in a timely manner for 1 of 1 residents observed during medication administration (#56)

Findings:

During the medication administration observation task on at 9:39 AM with RN #A, she was observed pour a pill, Vesicare, from a plastic card that was taken from a box. She said it was a sample from the physicians office and she was using the samples until the medication was delivered from the pharmacy. She said she did not know when the medication was expected to arrive from the pharmacy. The sample boxes were not labeled with the resident name or dose.

Review of the record revealed a physician's order dated for Vesicare 10 milligrams once a day. During an interview with the unit manager (UM) on at 4:40 p.m., she said the Vesicare will arrive today. When asked when it should have arrived, she said the day after it was ordered. She said she spoke with the pharmacy and they informed her they did not receive the faxed order on

The policy and procedure for medication ordering and receiving from pharmacy indicates medications are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. In the section for receiving

(3) Licensed Nurses were re-educated on Missing medications , medication Pending Report, Medication Exception Report, 24 Chart Check and the ordering of medications through Pharmacy in a timely manner. On Pharmacy in-serviced the licensed nurses on various topics such as: "Never accept sample medications," " All medications must have a prescription label "and "prescriptions must be dispensed through a pharmacy".

Pharmacy conducted MAR to Cart Review on and will be ongoing.

(4) Director of Nursing and Unit Managers will complete random audits throughout each shift for 4 weeks to validate that there is no missing medications, and that medications will be ordered through pharmacy in a timely manner. The Director of Nursing/Designee will review the audits and submit the findings to the QA Committee Members monthly. The QA Committee will determine whether there is need for additional auditing and if further education or revision to the plan is needed.

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N 090	Continued From page 4 medications from pharmacy it lists: the nurse promptly reports discrepancies and omission to the issuing pharmacy and the charge nurse/supervisor. The UM then stated she did not have a record of when the order was faxed. she said the facility should not be using the sample medication that was not supplied by the pharmacy that had no label. The nurses should have checked with the pharmacy to see when the medication was expected to arrive, and not continue to use the samples without asking. Class III	N 090	(4) Random medication cart audits will be conducted weekly x4 by the Pharmacist or DON/Designee and then monthly there after and results will be brought to QAA for follow up education or actions.	
N 094 SS=D	59A-4.112(5), FAC Drug Labeling Drugs and biologicals used in the facility shall be labeled in accordance with currently accepted professional principles, Chapter 499, F.S., and Chapter 64B16, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure medications were labeled appropriately for 1 of 1 residents observed during medication administration (#56) Findings: Two boxes of medication, Vesicare, were observed during the medication administration observation task on at 9:39 AM with RN #A. The nurse administered the medication taken from the box. She verified the boxes had no labels. She said she thought they were samples from the urologist.	N 094	**N 094** (1) RN # A was in-serviced on Medication Administration and medications labels. Pharmacy was notified and medication was obtained. 2) No other residents had medication with missing labels (3) Licensed nurses were in-serviced on medication administration; the ordering/receiving medication from the Pharmacy; the appropriate components pharmacy labeling on	11/16/14

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N 094	Continued From page 5 In an interview with the unit manager on at 4:40 p.m., she confirmed the medication samples should not have been used without a label. Review of the facility policy and procedure for medication labels read, only the pharmacy/registered pharmacist and modify, change, or attach prescription labels. The procedure included all the information needed on a label. Medications dispensed by physicians must conform to labeling requirements. Class III	N 094	**N 111 Housekeeping & Maintenance Services, Physical Environment Specifics**	11/16/14
N 111 SS=E	59A-4.122(2), FAC Physical Environment - Specifics The facility shall provide: (a) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; (b) Clean bed and bath linens that are in good condition; (c) Private closet space for each resident; (d) Furniture, such as a bed-side cabinet, drawer space; (e) Adequate and comfortable lighting levels in all areas; (f) Comfortable and safe temperature levels; and (g) The maintenance of comfortable sound levels. Individual radios, TVs and other such transmitters belonging to the residentwill be tuned to stations of the resident ' s choice. This Statute or Rule is not met as evidenced by: Based on observations and interview, the facility failed to ensure furniture and fixtures were clean and in good repair in 2 out of 2 wings (North and South Wings.)	N 111	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. 1) The privacy curtain in have been removed/replace with clean or new curtains. Completed: The door frame in has been repaired and is free of rust and the baseboard has been repaired/ or replaced and is no longer coming off the wall. Completed:	

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N 111	Continued From page 6 Findings: North Wing 1. On at 2:00 p.m. , the privacy curtain for bed A had grayish stain on it. At 1:50 p.m. , frame inside the shared rusted; the baseboard below the window was coming off the wall. At 3:00 p.m. , the wall near the air conditioning unit was peeling. At 11:15 a.m. , the was gouged and in need of painting; a cabinet under the sink located near residents' closet has peeling veneer exposing sharp edges that can catch clothes or skin. At about 11:15 a.m. , the was gouged and in need of painting. At 11:20 a.m. the was gouged and in need of painting; baseboards inside the separating from wall. At 11:25 a.m. , the doors were scuffed and in need of painting; baseboards were peeling off wall in the 2. On at about 11:00 a.m. , a ceiling tile was broken leaving a hole above Bed B. At 11:15 a.m. there were scratches and unfilled holes on the 3. On 12:20 p.m. North wing nurse station, veneer/ is peeling off in several areas around the nurse station. South Wing 4. On at about 3:00 p.m. , the dry wall by the air conditioning (A/C) unit was peeling off. There was a trace of water leakage near the A/C unit. A baseboard by the residents' closet was peeling.	N 111	the wall has been painted and is free of peeling. Completed: the has been painted/repaired/ or replaced. The veneer on the cabinet under the sink has been repaired/ or replaced. Completed: 136 and 134, have been painted and the baseboard in has been re-applied to the wall. Completed: has been and baseboards have been re-applied to the Completed: ceiling tile has been replaced. Completed: holes in the door were filled and repainted. Completed: the wall has been repaired and baseboard re-applied. The AC unit has been checked and is in proper working condition with no leaking. Completed:	

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N 111	Continued From page 7 5. On at about 3:10 p.m. paint coming off walls and cracks in wall around fixtures in the resident's At 3:00 p.m. , a night stand for Bed A was in disrepair, i.e. all 3 drawers were out of tracks and edge veneer was missing around the table top of the night stand. The the same the resident's closet door was bent inward. 6. On at 12:25 p.m. South wing Nurse station. Veneer baseboards and around the counter are coming off exposing sharp edges that could be caught on clothes and/or skin. An activity cabinet under the television set has missing glass panel on the door. A facility environmental tour was conducted with the director of facility services on from 1:15 p.m. to 1:45 p.m. The above observations were discussed and verified with him during the tour. Pattern Class III	N 111	walls have been checked for cracking/repaired and painted. Completed: night stand has been replaced. Closet door has been repaired and is in proper working condition. Completed: The glass door under the Activity cabinet has been removed making cabinet into shelf. Completed: Both North and South wing nurses stations have been evaluated for best possible solution for repair. Bids have been received and a process has been selected to repair and improve the appearance and safety of the working area/surface of both nursing stations. Contracted work expected completion by: N 111 cont.	
N 201 SS=G	400.022(1)(l), FS Right to Adequate and Appropriate Health Care The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by:			

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N 111	Continued From page 7 5. On 10/13/14 at about 3:10 p.m. paint coming off walls and cracks in wall around fixtures in the resident's At 3:00 p.m. a night stand for Bed A was in disrepair, i.e. all 3 drawers were out of tracks and edge veneer was missing around the table top of the night stand. The the same , the resident's closet door was bent inward. 6. On at 12:25 p.m. South wing Nurse station. Veneer baseboards and around the counter are coming off exposing sharp edges that could be caught on clothes and/or skin. An activity cabinet under the television set has missing glass panel on the door. A facility environmental tour was conducted with the director of facility services on from 1:15 p.m. to 1:45 p.m. The above observations were discussed and verified with him during the tour. Pattern Class III	N 111	An inservice was provided to Housekeeping and Maintenance staff involved in the daily cleaning and maintenance of the with focus on sanitary, correctly operating/orderly and providing a comfortable environment. Nursing staff have also been inserviced on proper way to notify Maintenance or Housekeeping of any cleaning, furniture or using the TELS maintenance tracking reporting system. Completed: 2) The Director of Plant, Administrator/or designee have conducted rounds on a daily basis to observe for clean, orderly, and comfortable interior. 3) will be brought to morning meeting and discussed using the sheets and the QIS tool document prepared by the Department Head team. Any immediate concerns will be addressed.	
N 201 SS=G	400.022(1)(l), FS Right to Adequate and Appropriate Health Care The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by:			

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N 111	Continued From page 7 5. On at about 3:10 p.m. paint coming off walls and cracks in wall around fixtures in the resident's At 3:00 p.m. , a night stand for Bed A was in disrepair, i.e. all 3 drawers were out of tracks and edge veneer was missing around the table top of the night stand. The the same , the resident's closet door was bent inward. 6. On at 12:25 p.m. South wing Nurse station. Veneer baseboards and around the counter are coming off exposing sharp edges that could be caught on clothes and/or skin. An activity cabinet under the television set has missing glass panel on the door. A facility environmental tour was conducted with the director of facility services on from 1:15 p.m. to 1:45 p.m. The above observations were discussed and verified with him during the tour. Pattern Class III	N 111	4) The Administrator, Plant Director, Director of Nursing/designee will review daily and weekly findings from the daily sheet and the QIS tool documents which will be presented to the QA committee for 3 months and then randomly thereafter. **N 201**	11/16/14
N 201 SS=G	400.022(1)(l), FS Right to Adequate and Appropriate Health Care The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by:	N 201	1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 86. Immediate Corrective Actions: a. CNAs #C and # D were immediately suspended, investigation completed and both employees were terminated.	

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N 201	Continued From page 8	N 201		

Based on observation, interview, and record review the facility failed to provide care in a manner to promote the highest practicable mental, psychosocial, and physical well being for a resident with who resisted care that resulted in substantial distress and physical injury for 1 of 1 resident reviewed out of 31 sampled residents (#86) and the facility failed to keep the drug regimen free of unnecessary medications for 1 of 6 residents reviewed for unnecessary medications of 31 sampled residents (#86).

Findings:

1. Record review revealed resident #86 was admitted to the facility on with diagnoses including, but not limited to, and adult . The current minimum data set (MDS) assessment dated indicated the resident had severe . She is usually understood and can express her needs. She has no hallucinations or . She exhibits physical behavioral symptoms directed towards others such as, hitting, kicking, pushing, scratching 1-3 days a week. She rejects care 1-3 days a week. The resident is always of and frequently of bowel. She requires with activities of daily living.

On at 11:07 a.m., resident #86 was heard yelling. The the resident's door was closed, but the resident could be heard from the common area outside her After a staff person in the permission to enter, observation revealed resident #86 was the only

b. The nurse, employee # B was immediately suspended pending investigation and reinstated following completion of the investigation. The nurse employee is currently participating in ongoing education regarding assessment and response to residents with behaviors.

c. Resident # 86 was immediately re assessed by the IDT for management of her current physical, mental and psychosocial wellbeing. Behavioral Observation was done to attempt to identify potential patterns and triggers; Pain re-assessment conducted, and medication review was conducted by the Pharmacist in conjunction with the IDT.

d. Hospice, the primary physician, psychiatrist, affiliated consultants, family, and primary care staff were involved in the review, revision, and updates to her individualized plan of care. She has resumed her usual preferred routines.

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N 201	Continued From page 9 resident in the She was yelling, "get out." She was attempting to kick, bite, and hit 2 certified nursing assistants (CNAs) # C and #D. The resident continued to tell the CNAs to "get out of here," but they did not stop care and/or step away. CNA #D was holding both of the resident's hands tightly and the resident was trying the break free of her grip. CNA #C was attempting to button the resident's shirt and the resident continued to yell and made repeated attempts to bite, kick, and hit the CNAs. Neither CNA #D, nor CNA #C stopped attempting to provide care despite the resident's repeated requests for them to get out and the resident's continued attempts to kick, hit, and bite them. The resident was visibly distressed. Both CNAs began to laugh at the resident as she resident continued to try to bite them and kick them. When asked why they continued to ignore the resident's requests to stop, they said they continued because the resident was soiled with bowel movement and they had to clean her. They said she then would not let them dress her, so they held her hands so she couldn't hit them. Within a few minutes, the Unit Manager (UM) was informed of the observation and she entered the The resident was visibly upset and was yelling and screaming as she was saying, "help me" and "get out of here." She was still trying to hit, bite, and kick the CNAs while they stood at the bedside. They did not attempt to speak to the resident in a calm and respectful manner. At that time CNA #D said to the UM, "this resident is crazy" in the presence of the resident and the UM. The UM then asked both CNAs to leave the she stayed with the resident. Later the same day, at 11:20 A.M. licensed	N 201	2. Those Potentially Affected by the alleged deficient practice as noted within F309: a. All residents with a diagnosis of ; other and high risk behaviors were identified. b. Identified Residents were re assessed by the IDT for management of their current physical, mental and psychosocial wellbeing with care plan updates as indicated. There were no others noted to have been affected by the alleged deficient practice. c. Pain re-assessment is ongoing on designated residents with haviors/psych to rule out pain as a causative factor. Medication reviews were conducted for designated residents by the Pharmacist in conjunction with the IDT. d. Behavioral Monitoring is ongoing on designated residents with a known hx of behaviors affecting others, or refusals of care to identify potential patterns and triggers	

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N 201	Continued From page 10 practical nurse (LPN) #B was observed preparing medication and walked into resident #86's. When she exited the said it was 0.25 milligrams (mg) and it was ordered as needed (PRN) for agitation. She said the resident would not take it so she was going to call the physician to ask for an medication to be given via an injection. In an interview with CNA #C and #D on at 11:30 a.m., CNA #D said she was assigned to care for resident today and she was familiar with resident #86. She said the resident is not always resistant to care, it depends on her mood. When she entered the resident's deliver care she said the resident told her to get out. She said she reported it to the nurse who instructed her to take another staff member with her to provide care. CNA #D said she did not want to leave the resident who was of BM at that time without cleaning her even though the resident was refusing care at that time. CNA #B said "when a resident resists care we usually come back later, but we could not leave the resident soiled." When asked why they did not stop and step away as the resident continued to refuse and became more and more agitated, they said, "we had to finish because we could not leave her that way. What else were we supposed to do? We couldn't let her hit us." During an observation on at 12 p.m., the resident was observed being taken out of her a wheeled recliner chair. At that time, the UM said the resident was upset and continued to kick and swing at her for the next 40-45 minutes. During that time, she said she stayed in the with the resident to observe her, but out of her reach and spoke to the resident in a calm	N 201	e. A 100% audit of the Care Plans/Kardex for the identified residents was conducted and corrections were made on f. Updates to care plans and Kardexes were provided through education, shift reports, and skills fair activities. g. Residents will be discussed as indicated at Daily Ops and Clinical Quality Reviews, Weekly QOL meetings, and as part of daily, weekly, and monthly QAA/QAPI activities. 3. System Changes and Measures were put into place to ensure that the alleged deficient practice does not recur includes: a. Director of nursing/designees provided education to nursing staff on F309, F241, and F329 "Know Your Role" and Pain Management training by Hospice and Dr. Miller on	

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N 201 Continued From page 11

manner. She said the resident refused the pill, so she instructed the nurse to call the physician to ask for a medication that could be given via injection. The UM said the resident eventually became calmer and agreed to finished getting dressed and transfer to the chair with staff assist. The physician ordered 0.5 mg one time for agitation, but the UM said they did not need to give it because she was able to help the resident become calmer and allow care.

On at 12:40 p.m., the resident was observed being taken away from the lunch table by CNA #E. "Refused" was marked on her meal ticket. The resident was calm and was not yelling, kicking or hitting. In an interview with CNA #E at that time she said resident would not eat. She said she has cared for the resident before and depending on the resident's mood she will feed herself, let staff assist, or refuse.

In an interview withe the UM at at 12:55 p.m., she said she thought the both CNAs behavior was not acceptable. They did not treat the resident with dignity or respect. She thought the resident's distress could have been avoided had the CNAs not continued to provide care when the resident first expressed her wishes for them to get out. They should have not have started care against the residents wishes and should not have continued when the resident became extremely upset. She said she thought what happened to the resident was not acceptable and they should have done a better job caring for a resident with because they care for many residents with "That is the type of residents we care for."

Review of the facility assignments

N 201

c. "Walk in the Shoes" of the resident Training on with continuation during

d. The Hand in Hand Series was conducted for sessions 1-4 on the following dates: – Module 1; – Module 2; – Modules 3 &4.

e. Director of Nursing, ADON, and IDT Members provided all day skills training on and 5th. Topics included: Hand in Hand Reinforcement, Stop and Watch, and SBAR reporting, Food Handling, and Control, survey competencies.

f. The Director of Nursing, ADON, and designated MDS/Unit Managers are conducting clinical rounds using the All About Me tool to reaffirm resident choices and preferences.

g. The Use of Therapeutic Activities at the bedside and types of activities developed specific to those with was provided by external Activities consultants on 11/5 and

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N 201	Continued From page 12 and revealed CNA #D was the CNA who cared for the resident every day she worked for 8 shifts in and 22 shifts in CNA #C worked 19 shifts in and 11 shifts on . The facility had consistent assignments. On 3:55 p.m. the resident was observed in TV area in the recliner chair across from her . She was listening to the music program and alternatively closing eyes. The first knuckle on the back of her right hand was red and . On at 10:15 a.m. the resident was observed in bed eyes with her eyes closed. After a knock on the door, she opened eyes and spoke calmly. The first knuckle on the back of the right hand was red, , and had a purple area extending towards her fingers. The knuckle on the right hand middle finger was red. The resident smiled and moved her right hand freely. In an interview with the UM on at 10:30 a.m., she said the resident initially complained of pain in her right hand on and said "they hurt me" as she pointed to her right hand. She said the physician was notified and an X ray was obtained. It was negative for of the hand and showed . The UM said the resident became calm after she stepped away from the bedside and spoke to her in a calm manner. In an interview with the hospice CNA caring for the resident on at 12:19 p.m., she said she is aware the resident can be combative with care, but she said it depends how you approach the resident. She said if the resident says no and/or attempts to swing at her, she steps away and tells the nurse that the resident refused care at that time. She said usually she can go back	N 201	h. External Activities Consultant providing on site visits for next 4 weeks to further develop person centered programming with "All About Me" data. i. Education on bedside and on unit activities for C.N.A. staff was provided on j. Hand in Hand Training will be included in ongoing orientation and staff education offerings. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: a. Will conduct a random care audit of (2) residents identified with or related with the potential for behavioral manifestations weekly for four (4) consecutive weeks b. DON/Designee will conduct a random audit of two (2) residents receiving Pain Management a minimum of 3 times weekly for 3 months. c. The Adm/Activity staff or designee will perform on unit rounds a minimum of 3 x weekly for 3 months to ensure comfort care alternatives are in place and working effectively	

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N 201	Continued From page 13 and sit with the resident and hold her hand, she will not become combative or agitated, and she will agree to care. She said she often works with another hospice CNA, but they provide care in small steps and explain each step of care along the way. The social services director was interviewed on at 10:50 a.m. regarding how she determines what to document on the MDS assessment regarding resident #86's behavior. She said she documents in her social service progress notes what she retrieves from nurses notes, hospice notes, and CNA interviews. She said her behavior is calm when she is in the recliner chair out in atrium. She said it depends on her mood on whether or not she allows care. The quarterly review notes dated indicated the resident has episodes of crying and restlessness at times and she also becomes combative with ADL care and will attempt to kick and scratch caregivers. The notes did not address any attempt to determine why the resident exhibits the behaviors or that the resident received orders for PRN in addition to routine for increased agitation after the resident refused care on Review of the record revealed the physician's progress note dated noted nursing staff report increased agitation. Nurses notes documented the resident refused care and was kicking, hitting, and spitting. The physician wrote an order dated to receive 0.25 mg every 6 hours related to and agitation. Review of the medication administration record (MAR) revealed the resident received the PRN in addition to the routine on 8 occasions from to The nurse, LPN #B, attempted to give the again on	N 201	d. The DON/designee will audit for the Use of the Stop and Watch System and Shift Huddles weekly x 3 for 4 weeks and then ongoing as part of the facility QAA e. Quality reporting systems will be used to evaluate Casper QM data, Pain and use, and related indicators and to develop or enhance PIP's as indicated. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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N 201	Continued From page 14	N 201	Page intentionally left blank.	

for refusing care and being combative with staff and when the resident refused, she planned to get an order to give her an injection.

A care plan was initiated on for and a history of agitation, and . The care plan included interventions to: observe for agitation during care-step away and re-approach if needed. On the interventions was added to talk resident through each care routine, step away if needed if resident becomes combative. The care plan did not include interventions to give the resident PRN when she became combative, although staff interviews and documentation revealed the resident was given the medication for refusing care.

In an interview with RN #F on 10:33 a.m., he said he will give the PRN when the CNAs tell him the resident is agitated when they want to give care. He said he did not does see combative behavior because she is usually calm with him. In an interview with LPN #B on 10:16 a.m. she said the resident gets combative when she gets bothered. She said the resident had the behavior approximately 1-3 times a week. She said if the resident is agitated when the CNAs want to give care, they tell her so she can administer the PRN .

On at 3:55 p.m. the director of nursing was asked to provide any policies or procedures for care of residents with and behaviors. On she provided a policy for and neglect. The policy referred to a catastrophic reaction as an extraordinary reaction of residents to ordinary stimuli, such as the attempt to provide care. The heading of "identification, correction and intervention in

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N 201	Continued From page 15 ıeglectful situations " included: deployment of staff to meet the needs of the residents and assure staff have the knowledge of the individual residents' care needs; supervision of staff to identify inappropriate behaviors; assessment, care planning, and monitoring of resident with needs and behaviors with might lead to conflict or neglect, such as residents with aggressive behaviors. The facility Clinical Protocol for Problematic Behavior Management included: identify individuals with cognition , document details about behavior such as onset, frequency, and precipitation factors, document features of any changes over time, staff will use protocols to identify pertinent interventions, other than medications, for the nature and causes of the individual's behavior. The policy for Behavior Assessment and Monitoring indicated the facility will comply with regulatory requirements related to the use of medications to manage problematic behavior. The "monitoring" section of the policy indicated staff will document in progress notes or behavior assessment forms the following information: number and frequency of episodes, preceding or precipitating factors, interventions attempted, and outcomes associated with interventions. During a meeting with the Administrator, DON, UM for 200 wing, and acting ADON/Independent Nurse Consultant for all Avante buildings on 10:30 a.m., the events of the previous day involving resident #86 were discussed. They all confirmed the manner in which the resident was cared for was not acceptable and the resident sustained avoidable substantial distress. At that time the education for care of residents with . exhibiting resistance to care was discussed. Although the DON and acting DON	N 201	Page intentionally left blank.	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 74809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED

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N 201	Continued From page 16	N 201	Page intentionally left blank.	

described training in progress, they indicated the UM completes random observations of care and they had no formal process to observe care of CNAs/nurses and document findings. They had not provided the free Centers for Medicare and Medicaid Services training for Person-Centered Care of Persons with and Prevention of to their staff.

2. Resident #86 was admitted to the facility on with diagnoses including but not limited to: and adult . Review of the physicians orders revealed the resident was receiving 0.5 milligrams (mg)3 times a day for agitation on . The target behaviors listed on the behavior/intervention flow record listed the target behaviors as and hallucinations. Specific agitated behaviors were not listed. The behavior flow records for and indicate the resident had no or hallucinations. The form included a section such as redirect, one on one, change position for interventions and it listed "medication-should not be first intervention."

On nurses notes indicated the resident was very agitated and refused for staff to give care. The resident was kicking, hitting, and spitting at staff. A new order was received for 0.5 mg now. Another order was received on for 0.25 mg every 6 hours for agitation. The physicians note indicated nursing staff reports increased agitation and it was most likely due to , will rule out process. The only behavior documented in the nursing notes for was when the resident became combative with care on and . The social service notes documented the resident becomes combative with ADL care

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	74809	A. BUILDING: ______ B. WING ______	10/16/2014

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N 201	Continued From page 17	N 201	Page intentionally left blank.	

and will attempt to kick and scratch caregivers. The documentation did not include any attempts at identifying the cause of the behavior or any non pharmacological approaches.

Resident #86 had a care plan for medication related to initiated on and revised on . The goal was for the resident to be free of discomfort or adverse reactions related to medications. One of the interventions was to administer the medication per the physician's order. The care plan did not include any listing of non pharmacological interventions.

On at 11:07 a.m., resident #86 was heard yelling. An observation at that time revealed she was in her she was yelling, "get out." She was attempting to kick, bite, and hit 2 certified nursing assistants (CNAs) # C and #D. The resident continued to tell the CNAs to "get out of here," but they did not stop care and/or step away. CNA #D was holding both of the resident's hands tightly and the resident was trying the break free of her grip. CNA #C was attempting to button the resident's shirt and the resident continued to yell and made repeated attempts to bite, kick, and hit the CNAs. Neither CNA #D, nor CNA #C stopped attempting to provide care despite the resident's repeated requests for them to get out and the resident's continued attempts to kick, hit, and bite them. The resident was visibly distressed. Both CNAs began to laugh at the resident as she resident continued to try to bite them and kick them. When asked why they continued to ignore the resident's requests to stop, they said they continued because the resident was soiled with bowel movement and they had to clean her. They said she then would not let them dress her,

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so they held her hands so she couldn't hit them.

At 11:20 A.M. licensed practical nurse (LPN) #B was observed preparing medication and walked into resident #86's When she exited the said it was 0.25 milligrams (mg) and it was ordered as needed (PRN) for agitation. She said the resident would not take it so she was going to call the physician to ask for an medication to be given via an injection.

Review of the medication administration sheet revealed the resident received the extra doses of 9 times from to RN #B gave the PRN 4 of the 9 times and LPN #B gave the PRN 2 of the 9 times and attempted an additional time on

In an interview with RN #F on 10:33 a.m., he said he will give the PRN when the CNAs tell him the resident is agitated when they want to give care. He said he did not does see combative behavior because she is usually calm with him. In an interview with LPN #B on 10:16 a.m. she said the resident gets combative when she gets bothered. She said the resident had that behavior approximately 1-3 times a week. She said if the resident is agitated when they want to give care, they tell her so she can administer the PRN

Review of nurses notes revealed the specific behaviors exhibited that resulted in the resident receiving the extra doses of were only documented as either , agitation, or restlessness, although the behavior that precipitated the order for the extra dose of was refusing care on Non

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N 201	Continued From page 19 pharmacological interventions or other behavioral interventions were not documented. Class II		**N203**	11/16/14
N 203 SS=G	400.022(1)(n), FS Right to be Treated with Dignity The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and an oral explanation of the services provided by the licensee, including those required to be offered on an as-needed basis. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to treat a resident with with dignity and respect when the resident refused care for 1 of 31 sampled residents (#86). Due to this failure, the resident sustained psychosocial harm. Findings: On at 11:07 a.m., resident #86 was heard yelling. The the resident's door was closed, but the resident could be heard from the common area outside her After a staff person in the permission to enter, observation revealed resident #86 was the only resident in the She was yelling, "get out." She was attempting to kick, bite, and hit 2 certified nursing assistants (CNAs), # C and #D. The resident continued to tell the CNAs to "get out of here," but they did not stop care and/or step away from the resident. CNA #D was holding both of the resident's hands tightly and the resident was trying the break free of her grip.	N 203	1. Immediate action(s) taken for the resident(s) found to have been affected include: a. On CNA #C and CNA #D were immediately removed from Resident #86 care and was suspended pending investigation. On investigation was completed and CNA#C and CNA #D were terminated. b. Resident #86 was immediately reassigned to a familiar staff member, was reassessed for comfort, and provided with care interventions. She accepted care with a continued calm demeanor. c. Ongoing reassessment has included Medication Review by the Consultant Pharmacist, and attending Physician, Pain Assessment, and Behavioral monitoring to identify potential patterns and triggers. Hospice, the	

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N 203	Continued From page 20 CNA #C was attempting to button the resident's shirt and the resident continued to yell and attempt to bite, kick, and hit the CNAs. They did not stop attempting to provide care despite the residents repeated requests for them to get out and the resident's attempts to kick, hit, and bite them. The resident was visibly distressed. Both CNAs began to laugh at the resident as she resident continued to try to bite them and kick them. When asked why they were continuing to ignore the resident's requests to stop, they said they continued because the resident was soiled with bowel movement and they had to clean her. They said she then would not let them dress her so they held her hands so she couldn't hit them. Within a few minutes, the Unit Manager (UM) was informed and she entered the ...... The resident was visibly upset and was yelling and screaming as she was saying, "help me" and "get out of here." She was still trying to hit, bite, and kick the CNAs while they stood at the bedside. They did not attempt to speak to the resident in a calm and respectful manner even after the UM entered. At that time CNA #D said to the UM, "this resident is crazy" in the presence of the resident and the UM. The UM then asked both CNAs to leave the she stayed with the resident. In an interview with CNA #C and #D on at 11:30 a.m., CNA #D said she was assigned to care for resident that day and she was familiar with resident #86 because she cares for her every day she works. She said the resident is not always resistant to care. When she entered the resident's .... deliver care she said the resident told her to get out. She said she reported it to the nurse who instructed her to take another staff member with her to provide care. CNA #D said she did not want to leave the	N 203	primary physician, affiliated consultants, family and primary care staff were involved in the review, revisions and updates to her individualized plan of care. She has resumed her usual preferred routines d. Updates on resident specific preferences and interventions are being provided to primary staff through education, shift reports, and skill fair activities. 2. Identification of other residents having the potential to be affected was accomplished by: (1) All residents with a diagnosis of ; other ; and high risk behaviors were identified and reassessed by the IDT for management of their current physical, mental and psychosocial wellbeing. There were no others identified to have been affected by the alleged deficient practice a. Pain re-assessment is ongoing for identified residents.	

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N 203 Continued From page 21

resident who was .... of BM at that time without cleaning her even though the resident was refusing care at that time. CNA #B said when a resident resists care we usually come back later, but we could not leave the resident soiled. When asked why they did not stop as the resident continued to refuse and became more and more agitated, they said, "we had to finish because we could not leave her that way."

During observation on at approximately 12:00 p.m., the resident was observed being taken out of her ...... a wheeled recliner. The resident was calm and was not attempting to kick, hit or bite staff. At that time the UM said the resident was upset and continued to attempt to hit and kick her, but she eventually became calm because she did not attempt further care, watched the resident from a distance, and spoke to her in a calm voice. After she was calm, the UM said she was able to finish care.

In an interview withe the UM at .... at 12:55 p.m., she said she thought the both CNAs behavior was not acceptable. They did not treat the resident with dignity or respect. They should not laugh at resident's or call them names like "crazy." She thought the resident's agitation and distress could have been avoided had the CNAs not continued to provide care when the resident first expressed her wishes for them to get out. They should have not have started care against the resident's wishes and should not have continued when the resident became extremely upset. She said she thought what happened was not acceptable and they should have done a better job caring for a resident with .... because they care for many residents with .... "That is the type of residents we care for."

N 203

b. Observations are addressed in the morning clinical review.

c. A 100% audit of Care Pans/Kardex was completed for identified residents. Updates were added to individualized plans of care as indicated.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:

a. Inservice education programs were conducted separately with licensed and non-licensed staff by the Director of Nursing Services (DON)/designees. Topics include Resident Rights and Recognizing/Preventing .... completed on

b. Proper procedures for addressing resident preferences obtained from interview information were discussed. Altering care to accommodate resident choice were also addressed to assure the maintenance of resident dignity and respect.

c. The Director of Nursing, ADON, and designated MDS/Unit Managers are conducting clinical rounds on "All about Me" Questionnaires to reaffirm choices and preferences.

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N 203 Continued From page 22

Record review revealed resident #86 was admitted to the facility on with a diagnosis of . Review of her minimum data set assessment dated revealed the resident exhibited physical behaviors (hitting, kicking, pushing, scratching, or grabbing) 1-3 times per week and rejected care 1-3 times per week. She requires with all ADLs and has severe Social Services notes dated indicated the resident is able to make needs known to staff.

Class II

N 433 SS=B 400.191(5)(a)2, FS Nursing Home Guide Posted

(5) Every nursing home facility licensee shall:

(a) Post, in a sufficient number of prominent positions in the nursing home so as to be accessible to all residents and to the general public:
2. A copy of all of the pages that list the facility in the most recent version of the Nursing Home Guide.

This Statute or Rule is not met as evidenced by:
Based on observation and interview, the facility did not post all pages of the most current version of the nursing home guide.

Findings:

Observation on at 11:00 a.m. revealed the nursing home guide that was posted an area on the wall in the main hallway. The date of the guide was 1012. In an interview with the

N 203

d. The Director of Nursing/Designee provided education to nursing staff on F309, F241 and F329 in a series of education to include : "Know Your Role" and and Sensitivity training on "Walk in the Shoes", (Need to show continued presentations on this and the Know Your Role)

e. Pain Management training was done Hospice and Dr. Miller

f. The Hand in Hand Series Module 1 completed on 11/5. Module 2 to be completed by 11/7. Modules 3 and 4 to be completed by

g. An external Activity Consultant assisted with expansion of Therapeutic bedside Activities and will provide onsite visits for the next 4 weeks utilizing "All about Me" data.

h. Education on bedside and on the unit activities for C.N.A. staff was provided on 11/5.

i. An all-day skills fair for all staff was conducted on 11/4 and 11/5. Topics include Resident Dignity; Non-Verbal Communication; Identification of Pain; Resident Rights; Preventing

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N 433 SS=B	400.191(5)(a)2, FS Nursing Home Guide Posted (5) Every nursing home facility licensee shall: (a) Post, in a sufficient number of prominent positions in the nursing home so as to be accessible to all residents and to the general public: 2. A copy of all of the pages that list the facility in the most recent version of the Nursing Home Guide. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility did not post all pages of the most current version of the nursing home guide. Findings: Observation on at 11:00 a.m. revealed the nursing home guide that was posted an area on the wall in the main hallway. The date of the guide was 1012. In an interview with the			

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N 433 SS=B	400.191(5)(a)2, FS Nursing Home Guide Posted (5) Every nursing home facility licensee shall: (a) Post, in a sufficient number of prominent positions in the nursing home so as to be accessible to all residents and to the general public: 2. A copy of all of the pages that list the facility in the most recent version of the Nursing Home Guide. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility did not post all pages of the most current version of the nursing home guide. Findings: Observation on at 11:00 a.m. revealed the nursing home guide that was posted an area on the wall in the main hallway. The date of the guide was 1012. In an interview with the	N 433	**N 433 Nursing Home Guide Posted** Facility did not post all pages of the most current version of the nursing home guide. 1) When it was brought to the attention of the Administrator, both Administrator and Surveyor walked through correct location on-line were report is located. Report was printed and is now posted. Completed:	11/16/14

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N 433	Continued From page 23 Administrator on at approximately 1:30 p.m., he said he thought he posted the current version. The last update to the nursing home guide was 2014. Pattern Class	N 433	2) Administrator/ or Medical Records/or designee will monitor quarterly for proper printing and posting of the Nursing Home guide. 3) Posting of the Nursing Home guide will be shared at monthly QA meeting to ensure that proper date of report is maintained. 4) The Administrator, and or Medical Records or designee will review quarterly the book where this guide is posted and ensure that proper report is posted.	

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Avante At Orlando Inc
2000 North Semoran Boulevard
Orlando, FL 32807

RE: Recertification, Relicensure and Life Safety Code Surveys

Dear Administrator:

On , 2014-C , 2014, a Recertification, Relicensure and Life Safety Code surveys were conducted at your facility by representative(s) of this office.

The purpose of this visit was to determine if your facility was in compliance with requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found not in substantial compliance with the participation requirements.

Enclosed are the provider's copies of Form CMS-2567 (Statement of Deficiencies and Plan of Correction) and State (3020) Form. These forms reference the deficiencies that were identified during the visit.

A Plan of Correction (POC) for the deficiencies must be submitted to this Field Office 10 days after your facility receives the faxed Form CMS-2567. Failure to submit an acceptable POC within ten (10) days after receipt of the faxed statement of deficiencies may result in the imposition of remedies. You will be notified by telephone or fax if your POC is found to be acceptable. If your POC is found to be unacceptable, you will be informed in writing. The correction date indicated by the facility shall be after the date of survey exit. **Deficiencies shall be corrected no later than 2014.**

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

Recommended Remedies:

Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other sanction is warranted, we will provide you with a separate formal notification of that determination.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended. A change in the seriousness of the noncompliance found may result in a change in the remedy recommended. When this occurs, you will be advised of any change in remedy.

- A mandatory denial of payment for new admissions will be imposed , 2015 if substantial compliance is not achieved by that time.
- Termination of Medicare Agreement. We are recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on , 2015 if substantial compliance is not achieved by that time.
- Civil Money Penalty, in an amount and duration to be determined by CMS.

Informal Dispute Resolution:
In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Attention: IDR Coordinator
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 9-A
Tallahassee, Florida 32308
FAX (850) 414-6946
or
Phone number: (850) 412-4301
IDRCoordinator@ahca.myflorida.com

The IDR request must be sent during the same 10 days you have for submitting a Plan of Correction for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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). If you have questions, please contact Theresa DeCanio at (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

TDC/al
Enclosures: CMS-2567 and State Form 3020

GHLL