Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943069	A. BUILDING: _____ B. WING _____	12/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SHORE RETIREMENT RESIDENCE	1500 NORTH RIVERSIDE DRIVE POMPANO BEACH, FL 33062

(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) COMPLETE DATE
A 000	Initial Comments An unannounced licensure complaint survey, #2019014060, was conducted on . . . . . , and . at Atlantic Shore Retirement Residence. The facility had deficiencies identified at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of . . . . . or . , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel	A 025		

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A 025	Continued From page 1 independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review, observation, and interviews, it was determined the facility failed to provide appropriate supervision and maintain written record of any illnesses that resulted in medical attention, or other changes that resulted in the provision of additional services to a resident, for 2 out of 3 sampled residents (Resident #1, Resident 9). Cross reference A 0079 The findings include: 1.On at approximately 11:30 AM an interview was conducted with Resident #1 family member. It was revealed, Resident #1 had 3 unexplained injuries and 1 injury resulting in a hospital visit requiring 12 stiches. Review of the facility's Assisted Living Facility (ALF) incident reports regarding Resident #1 revealed the following. Resident #1 was cut on his left arm; due to an unknown reason on . Resident	A 025		

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A	Continued From page 2 #1 right was injured from side rails on , resulting in a . Both reports lacked documentation indicating the description of the incident and circumstances under which the incident occurred documented. Review of resident #1 medical record revealed an order, dated ; for care orders for , left . Review of Resident #1 observation notes revealed no notes documenting this incident or resident receiving home health care for care. At this time, the Administrator was questioned and revealed the resident received home health care, however the facility does not have any written record of the incident. Further review of incident reports (photographic evidence obtained) revealed, Resident #1 cut his left on his wheelchair and required emergency care services on . Resident #1 received 12 stiches from the incident. The report lacked documentation indicating the description of the incident. Circumstances under which the incident occurred documented, "placed in wrong area on chair". It also indicates steps taken to prevent recurrence documented, "will encourage to ask for assistance". Name of residents or individuals, if any witnessed or were involved in incident documents, Staff F and Staff H. The form was signed by the Administrator on . At this time, the Administrator demonstrated the incident that occurred on . Observation was made of the Administrator getting a facility wheel chair and pointing out the arm rest and the vertical metal side panel, located directly under the rail. The Administrator indicated Resident #1 grabbed the side panel instead of the rail and revealed if the Resident uses all of their to get up and grab the side panel, the panel can	A 025		

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A 025	Continued From page 3 become sharp. It was also revealed that the Administrator did not physically observe the incident, but Staff F did. On an interview was conducted with Staff F, revealing Staff F was not at the facility during the time of the incident that occurred on . On at 10:23 AM, the Assistant Administrator was questioned about an injury that occurred on . It was revealed that facility Staff observed Resident #1 attempt to transfer from wheel chair to recliner chair and staff was not standing close enough to tell Resident #1 to wait for assistance. Review of Resident #1's Health Assessment (AHCA form 1823) dated confirms the resident requires assistance with ambulation and transferring. Resident's diagnosis is documented as "". The form documents the residents physical or sensory limitations as "decreased transfer". The form documents the residents or behavioral status as " , " and "". (Photographic Evidence Obtained) Therefore, the facility failed to provide the additional supervision based on Resident #1 requiring assistance with ambulation and transferring. The facility also failed to maintain a written record of care services home care services. 2. On at 10:00AM-2:00PM and at 7:00AM-9:AM and 11:00AM-3:00PM, observations of Resident #9 sitting in a recliner chair. On at approximately 11:00 AM, an attempt to interview Resident #9 was made. The resident did not respond and looked at surveyor with a blank stare. A review of Resident #9 resident file, revealed emergency room discharge papers, dated . Resident #9 was treated for a on , and received staples or	A 025		

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A 025	Continued From page 4 stiches. Follow up instructions noted to return to Emergency Room in 2 days for check and Staple/Suture removal in 10 days. (Photographic Evidence Obtained). Review of Resident #9 revealed the facility did not have any written documentation regarding the incident. Review of the incident report dated , document the injury occurred in Resident #9 bedroom, while trying to sit down in wheel chair. At this time, surveyor questioned Administrator on how she knows how the incident occurs. The Administrator stated she was not in Resident #9's bedroom during the incident on /1. However, in the past Resident #9 has when trying to sit down in her wheelchair and is assuming this happened on and no further investigation was conducted. A record review of the Healthcare Plan effective , revealed Resident #9 is in need of 24-hour services in an Assisted Living Facility setting due to functional limitations and/or medical conditions. On , an interview was conducted with the Administrator. It was revealed, the facility puts Resident #9 in the living room because the Administrator cannot trust her. The administrator stated, "We must keep her here because I don't have someone to sit with her, because I cannot trust that she can will not do it again. The interview confirmed, the facility is unable to provide 24-hour care for Resident #9. Further review of resident file revealed, Resident #9 was admitted on and requires assistance with all activities of daily living. The resident's diagnoses is documented as (AMS) and. AMS is usually referring to an abnormal change in behavior including speech, mobility, thought, and memory. (Photographic Evidence Obtained). On	A 025		

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A 025	Continued From page 5 at 2:50 PM, an interview was conducted with Staff F and confirmed Resident #9 never uses the walker on her own, and Resident #9 can't get up unless staff help her. If only 1 staff member is on duty the facility can not provide assistance with transferring resident #9. At this, time the findings were discussed with the Administrator. No additional information was received. Class III	A 025		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents — Staff Hours/Week 0-5 — 168 6-15 — 212 16-25 — 253 26-35 — 294 36-45 — 335 46-55 — 375 56-65 — 416 66-75 — 457 76-85 — 498 86-95 — 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care	A 079		

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A 079	Continued From page 6 services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and [illegible] ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and [illegible]. 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least [illegible] must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food	A 079		

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A 079	Continued From page 7 preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents'	A 079		

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A 079	Continued From page 8 contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by:	A 079		

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A 079	Continued From page 9 Based on observations, interview, and record review, it was determined that the facility failed to maintain an accurate staffing schedule to reflect its 24 hour staffing pattern and to ensure that adequate supervision and care are being provided to residents. The findings include: Review of the facility's staffing schedule for [redacted] and 6 prior months revealed the schedule was not accurate. It was noted that the Administrator and Assistant Administrator hours were only noted on 1 staffing schedule dated [redacted]. On [redacted] at 10:39 AM, an interview was conducted with the Administrator. It was revealed the Administrator and Assistant Administrator work the morning, afternoon, and evening shifts and various other hours throughout the week and that the Administrator is always at the facility. Upon arrival to the facility on [redacted] at 7:05 AM, it was noted that only one staff member (Staff D) was present for 14 residents. At this time, the Administrator stated she was present assisting with morning care on this morning but left around 5:00AM. Further review of the staffing schedule dated [redacted] revealed 1 staff member scheduled to work at the facility from 11:00 PM-7:00 AM . At this time, the Administrator revealed she does not put her hours on the schedule, however, she works during the day and was at the facility earlier assisting the morning home health aide bathe and dress the residents. Observations of the resident's care needs throughout the day on [redacted] and [redacted] and review of the Health Assessment forms (AHCA form 1823) revealed all of the resident (Resident	A 079		

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A	Continued From page 10 #1-#9) require supervision and/or assistance with their ADLs. If the sole person present is attending to one Resident's needs, no other staff is available to supervise and/or assist with care needs. This was evidence upon arrival and observations of Staff D attempting to assist Resident in bedroom; and no staff available (including supervising of 7 Residents in the living room). Class III	A 079		