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
	AL11964856	A. BUILDING: _____ B. WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE TEQUESTA	211 VILLAGE BLVD TEQUESTA, FL 33469

(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 Limited Nursing Services (LNS) monitoring survey was conducted on [redacted] at Brookdale Tequesta. The facility had deficiencies at the time of the visit.	A 000		
A 025 SS=G	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 [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. 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 independently in the community.	A 025		

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A 025	Continued From page 1 (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 observation, interview and record review, the facility failed to provide the level of care, services and oversight required to meet the needs of the resident. This was evidenced by the failure to ensure the physical well-being to 1 of 1 sampled resident's, (Resident #1), and the failure to follow internal policies to effectively communicate Resident #1 had a change in condition and development of a , . The findings include: In an interview with the Executive Director/Administrator and Registered Nurse (RN) Health and Wellness Director on at 8:50 AM, both stated that Resident #1 was being cared for under the facility's Limited Nursing Services (LNS) licensure. The Health and Wellness Director stated that Resident #1 had recently returned to the facility after a hospital admission and was admitted to hospice services. She stated that the facility nursing staff were monitoring Resident #1 for , , and ,	A 025		

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A 025	Continued From page 2 medical conditions. The Health and Wellness Director and Administrator stated that Resident #1 was not readmitted with any or /injury and did not have any current . In an observation on at 9:45 AM, Resident #1 was sitting in her wheelchair in the memory care dining room. The resident was observed to have an in place and continuous was being administered by a portable concentrator attached to the wheelchair. Resident #1 was also observed to have a collection bag attached to the wheelchair. In an interview with the Health and Wellness Director at that time she stated that Resident #1's and functions were being monitored by the facility nursing staff along with the hospice nurse, who visited the resident several times a week. When questioned, the Health and Wellness Director stated that the hospice nurse communicated about the resident's condition directly to the facility nursing staff after each visit. She stated that she has a weekly meeting with the hospice nurse to discuss resident status. Review of Resident #1's Agency Health Assessment form dated indicated medical diagnosis included , and insertion. The form indicated that Resident #1 has , is non-ambulatory, wheelchair bound and requires assistance with all activities of daily living (ADL) care. Further review indicated Resident #1 was receiving hospice services and being treated for a , to . Resident #1 required continuous , and an . Review of the form indicated discrepancies about the presence of the pressure	A 025		

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A 025	Continued From page 3 In an additional interview with the Health and Wellness Director on at 10:10 AM she stated that she had completed an initial LNS nursing assessment in the electronic medical record. In a review of the electronic record with the nurse at this time, the LNS assessment note indicated that Resident #1 was being monitored daily for function and status, which required continuous . The nurse stated that she had not completed and documented a nursing LNS assessment in Resident #1's medical record. Review of Resident #1's hospice medical record indicated that on the resident was assessed by the nurse on readmission to the facility memory care unit. The note indicated that Resident #1 had been hospitalized for an episode of , and while at the hospital, a had been inserted for and a inserted for . The note indicated that care was being completed for the post-surgical site and no additional were noted. Further review of the hospice nursing notes on indicated that Resident #1 was found with a soiled diaper, the resident was lying on top of the tubing and was observed to have an open, non- draining dime sized on the . Review of the hospice note dated indicated that Resident #1 was assessed to have a and orders were given to the facility nursing staff to utilize an over the counter until prescribed medication arrived at the facility. Resident #1 was observed to have	A 025		

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A 025	Continued From page 4 and in her lower extremities during the care. Review of the hospice care orders dated indicated to cleanse the area with care cleanser, , dry the , apply hydrocolloid thin to the area and cover with a transparent on a weekly basis and as needed by the facility staff. Review of a hospice note dated on indicated Resident #1's was described to have 100% , scant amount of bloody drainage and have no sign of . The note further indicated that a wedge cushion was ordered for positioning and instruction was given to the Health and Wellness Director to have Resident #1 turned and repositioned every 2 hours when in bed. Review of a hospice note dated indicated care was performed and the observed with 80% and 20% , measuring 1 cm x 1 cm x 0 cm. Review of the hospice note dated indicated that care was performed on Resident #1 and an old was noted to be dated . The note further indicated the to have scant bloody drainage, no odor and the peri- was dark and non- blanchable. In an interview with the hospice nurse on at 11:30 AM she stated that she had been caring for Resident #1 since her readmission to the facility memory care unit on . The nurse stated that Resident #1 was non-ambulatory, and wheelchair bound, and she required total ADL care. The nurse stated that she had completed an initial assessment on and confirmed that Resident #1 had no , or . The nurse stated that she visited Resident #1 again on and the resident's skin was intact, and	A 025		

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A 025	Continued From page 5 no observed. She stated that the resident had a for retention and wore a diaper for . The nurse stated that on the hospice visit, she noted that Resident #1 had developed an open area on the and care supplies/ medications were ordered. The hospice nurse stated that she had communicated to the facility nursing staff and management that the resident must be repositioned every 2 hours when in bed and the maintained intact. The hospice nurse stated that she instructed the facility nursing staff to use over the counter medication/cream until supplies arrived. On , the hospice nurse performed prescribed care and she noted signage above the resident's bed, which instructed care staff to turn and reposition the resident every 2 hours when in bed. The hospice nurse stated she visited Resident #1 weekly and had performed care on and . She stated that the was not but she had concerns that the would be compromised if the was removed. The hospice nurse stated that she had followed the facility's policy to complete the "Third Party Provider Collaboration Note" at each visit and she had discussed Resident #1's status, along with presenting the completed note to the staff nurse on duty in the memory care unit. Review of the facility electronic nursing notes for Resident #1 dating from readmission on indicated that the resident was under hospice care, required a . The note does not indicate any monitoring. Review of the progress note dated on indicated the resident was seen by the hospice nurse and care was completed, prior to this note there was no documentation	A 025		

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A 025	Continued From page 6 about assessment or monitoring of the resident's skin integrity. Review of the progress note dated on [redacted], indicated that the facility nurse changed Resident #1's [redacted], no further documentation about any observation of the [redacted] status was noted. The next progress note dated [redacted] indicated that [redacted] care was completed by the hospice nurse and the [redacted] is assessed as a [redacted]. Review of the progress notes from [redacted] to [redacted], indicated no documentation of facility nursing monitoring of the [redacted] or description of the [redacted] status and nursing services being provided to the resident. In an additional interview with the Health and Wellness Director on [redacted] at approximately 11:45 AM she stated that she was unaware that Resident #1 had developed a [redacted]. She stated that she had observed Resident#1 to have redness on the [redacted], but she was unable to recall the date of her observation and had not documented any of her observations in the resident's medical record. When questioned about the signage over Resident#1's bed, instructing staff to turn and position the resident every 2 hours, she stated she had posted that sign but could not recall the date. The Health and Wellness Director reviewed Resident #1's electronic medical record and stated that she would assume that care staff were following the instruction but could not provide any written documentation. The Health and Wellness Director stated that facility policy for communicating any open [redacted] included utilization of an "Open Area Flow Sheet". She stated that the staff nurse on duty would complete the form and returned it to the Health and Wellness Director for review. She stated that she had not received any flow sheets regarding	A 025		

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A 025	Continued From page 7 Resident#1's , or any "Third-Party Provider Collaboration Note" form for review. Review of the facility policy for "Open Area Documentation" dated on indicated that "residents with open areas should have regular documentation of the status of those areas by the community nurse, regardless of the third-party involvement." Further view of the facility policy indicated that within first noted appearance of an open area, an "Open Area Flow Sheet" form should be completed by a nurse in the community management. The policy indicated the form should be completed at a minimum weekly by the nurse and should be reviewed for completion and awareness by the Executive Director and Health and Wellness Director on a weekly basis. In an additional interview with the Health and Wellness Director and Executive Director on at approximately 12 noon, they provided a copy of an "Open Area Review Flow Sheet" dated on and signed by the memory care nurse and hospice nurse. Review of the sheet indicated that on , Resident #1 had developed a , measuring 1 cm x 1 cm x 0 cm which had scant drainage, no odor or , . The sheet indicated care orders were written along with instruction to turn and reposition the resident every 2 hours when in bed. Additional documentation was provided at the same time which included "Third Party Provider Collaboration Notes "dated on and indicated care performed on that day by the hospice nurse. The note indicated no change from last visit and described the . The form indicated that Resident #1 was complaining of , when moving from wheelchair to the bed. This form was signed by the memory care nurse	A 025		

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A 025	Continued From page 8 and the hospice nurse. Review of the facility electronic Medication Observation Record (MOR) for . . . . . indicated no , medication was administered to the resident on that date. Review of the "Third Party Provider Collaboration Notes" dated indicated care was completed on Resident #1 and no new changes or , was identified at the time of the visit and both the memory care nurse and hospice nurse had signed on the note. In an interview with the Executive Director on . . . . . at 12:15 PM she stated that the facility policy for communication failed because the nursing staff did not verbally communicate to the appropriate management personnel. She stated that completion of a form is not enough, it should always accompany verbal communication. She stated that the Health and Wellness Director had been out of the building from - which may have contributed to the situation. The Executive Director stated that she could not explain why facility care staff had not informed her about Resident #1's change in condition and development of a , ... starting on . The Executive Director was concerned that the nursing staff had not thoroughly documented observations of care and services being provided to the resident. The Executive Director stated that she was unaware that Resident#1's updated Health Assessment had documentation of the . . Class II	A 025		
A 077 SS=G	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators	A 077		

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A 077	Continued From page 9 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A new facility administrator must complete the required training and education, including the competency test, within 90 days after date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible];	A 077		

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A 077	Continued From page 10 2. If employed on or after . . . . . , . . . , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , , , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the . . . . . of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing	A 077		

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A 077	Continued From page 11 and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility administrator failed to provide adequate oversight and supervision of the facility staff to ensure appropriate care and services was provided to all residents. This was evidenced by	A 077		

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A 077	Continued From page 12 the failure to ensure implementation of the facility policy for the coordination and oversight of third-party services for care for 1 of 1 sampled resident, (Resident #1) who developed a . The findings include: In an interview with the Executive Director/Administrator and Registered Nurse (RN) Health and Wellness Director on at 8:50 AM, both stated that Resident #1 was being cared for under the facility's Limited Nursing Services (LNS) licensure. The Health and Wellness Director stated that Resident #1 had recently returned to the facility after a hospital admission and was admitted to hospice services. She stated that the facility nursing staff were monitoring Resident #1 for , , and medical conditions. The Health and Wellness Director and Administrator stated that Resident #1 was not readmitted with any or /injury and did not have any current . Review of Resident #1's Agency Health Assessment form dated indicated medical diagnosis included , and insertion. The form indicated that Resident #1 has , is non-ambulatory, wheelchair bound and requires assistance with all activities of daily living (ADL) care. Further review indicated Resident #1 was receiving hospice services and being treated for a , to . Resident #1 also requires use of continuous , , and an . Review of the form indicated discrepancies about the presence of the , .	A 077		

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A 077	Continued From page 13 Review of the facility electronic nursing notes for Resident #1 dating from readmission on [illegible] indicated that the resident was under hospice care, and as having a [illegible] in place. The note does not indicate any [illegible] monitoring. Review of the progress note dated on [illegible] indicated the resident was seen by the hospice nurse and [illegible] care was completed, prior to this note there was no documentation about assessment or monitoring of the resident's skin integrity. In an interview with the hospice nurse on [illegible] at 11:30 AM, she stated that she had been caring for Resident #1 since her readmission to the facility memory care unit on [illegible]. The nurse stated that she had completed an initial assessment on [illegible] and confirmed that Resident #1 had no [illegible] or [illegible]. The nurse stated that she visited Resident #1 again on [illegible] and the resident's skin was intact, and no observed. The nurse stated that on the [illegible] hospice visit, she noted that Resident #1 had developed an open area on the [illegible] and [illegible] care supplies/ medications were ordered. The hospice nurse stated that she had communicated to the facility nursing staff and management that the resident must be repositioned every 2 hours when in bed and the [illegible] maintained intact. The hospice nurse stated that she had followed the facility's policy to complete the "Third Party Provider Collaboration Note" at each visit and she had discussed Resident #1's status, along with presenting the completed note to the staff nurse on duty in the memory care unit. In an additional interview with the Health and Wellness Director on [illegible] at approximately	A 077		

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A 077	Continued From page 14 11:45 AM, she stated that she was unaware that Resident #1 had developed a . She stated that she had observed Resident#1 to have redness on the , but she was unable to recall the date of her observation and had not documented any of her observations in the resident's medical record. When questioned about the signage over Resident#1's bed, instructing staff to turn and position the resident every 2 hours, she stated she had posted that sign, but could not recall the date. The Health and Wellness Director reviewed Resident #1's electronic medical record and stated that she would assume that care staff were following her instruction but could not provide any written documentation. The Health and Wellness Director stated that facility policy for communicating any open included utilization of an "Open Area Flow Sheet". She stated that the staff nurse on duty would complete the form and deliver it to the Health and Wellness Director for review. She stated that she had not received any flow sheets regarding Resident#1's , or any "Third-Party Provider Collaboration Note" form for review. Review of the facility policy for "Open Area Documentation" dated on indicated that "residents with open areas should have regular documentation of the status of those areas by the community nurse, regardless of the third-party involvement." Further view of the facility policy indicated that within first noted appearance of an open area, an "Open Area Flow Sheet" form should be completed by a nurse in the community management. The policy indicated the form should be completed at a minimum weekly by the nurse and should be reviewed for completion and awareness by the Executive Director and Health and Wellness Director on a weekly basis.	A 077		

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A 077	Continued From page 15 In an additional interview with the Health and Wellness Director and Executive Director on at approximately 12 noon, they provided a copy of an "Open Area Review Flow Sheet" dated on which had been signed by the memory care nurse and hospice nurse.Additional documentation was provided at the same time which included "Third Party Provider Collaboration Notes "dated on and which indicated care was performed by the hospice nurse. In an interview with the Executive Director on at 12:15 PM, she stated that the facility policy for communication failed because the nursing staff did not verbally communicate to the appropriate management personnel. She stated that the forms were found located in an office and stated that completion of a form is not enough, it should always be accompanied with verbal communication. She stated that the Health and Wellness Director had been out of the building from - which may have contributed to the situation. The Executive Director stated that she could not explain why facility care staff had not informed her about Resident #1's change in condition, starting on or before and why the nursing staff had not thoroughly documented observations of care and services being provided to the resident. The Executive Director stated that she was unaware that Resident#1's updated Health Assessment dated on had documentation of the Class II	A 077		

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AN278	Continued From page 16	AN278		
AN278 SS=D	59A-36.022(3) FAC; 429.07 (3)(c)2, FS LNS - Records 59A-36.022 (3) RECORDS. (a) A record of all residents receiving limited nursing services and the type of services provided must be maintained at the facility. (b) Nursing progress notes must be maintained for each resident who receives limited nursing services. (c) A nursing assessment conducted at least monthly must be maintained on each resident who receives a limited nursing service. 429.07 (3)(c)2, FS A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain the required nursing progress notes and monthly nursing assessment note for 1 of 2 sampled residents receiving Limited Nursing Services (LNS), (Residents #1). The findings include: In an interview with the Executive Director/Administrator and Registered Nurse (RN) Health and Wellness Director on . . . . . at 8:50 AM, both stated that Resident #1 was being cared for under the facility's Limited Nursing Services (LNS) licensure. The Health	AN278		

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AN278	Continued From page 17 and Wellness Director stated that Resident #1 had recently returned to the facility after a hospital admission and was admitted to hospice services. She stated that the facility nursing staff were monitoring Resident #1 for , , and medical conditions. The Health and Wellness Director and Administrator stated that Resident #1 was not readmitted with any or , /injury. Review of Resident #1's Agency Health Assessment form dated indicated medical diagnosis included with , is non-ambulatory, wheelchair bound and requires assistance with all activities of daily living (ADL) care. Further review indicated Resident #1 was receiving hospice services and being treated for a to . The form indicated Resident #1 requires continuous , and an . Review of the form indicated discrepancies about the presence of the . In an additional interview with the Health and Wellness Director on at 10:10 AM, she stated that she had completed an initial LNS nursing assessment in the electronic medical record. In a review of the electronic record with the nurse at this time, the LNS assessment note indicated that Resident #1 was being monitored daily for function and status, which required continuous . The nurse stated that she had not completed and documented a full nursing LNS assessment in Resident #1's medical record, to include skin integrity. In an additional interview with the Health and Wellness Director on at approximately	AN278		

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AN278	Continued From page 18 11:45 AM she stated that she was unaware that Resident #1 had developed a . She stated that she had observed Resident#1 to have redness on the , but she was unable to recall the date of her observation and had not documented any of her observations in the resident's medical record. When questioned about signage over Resident#1's bed, instructing staff to turn and position the resident every 2 hours, she stated she had posted that sign but could not recall the date. The Health and Wellness Director reviewed Resident #1's electronic medical record and stated that she would assume that care staff were following her instruction but could not provide any written documentation. The Health and Wellness Director stated that facility policy for communicating any open included utilization of an "Open Area Flow Sheet". She stated that the staff nurse on duty would complete the form and deliver it to the Health and Wellness Director for review. She stated that she had not received any flow sheets regarding Resident#1's , or any Third-Party Provider Collaboration Note form for review. Review of the facility policy for "Open Area Documentation" dated on indicated that "residents with open areas should have regular documentation of the status of those areas by the community nurse, regardless of the third-party involvement." Further view of the facility policy indicated that within first noted appearance of an open area, an "Open Area Flow Sheet" form should be completed by a nurse in the community management. The policy indicated the form should be completed at a minimum weekly by the nurse and should be reviewed for completion and awareness by the Executive Director and Health and Wellness Director on a weekly basis.	AN278		

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AN278	Continued From page 19 Review of the hospice nursing notes on indicated that Resident #1 was found with a soiled diaper, the resident was lying on top of the , tubing and was observed to have an open, non- draining dime sized , on the , . Review of the hospice note dated indicated that Resident #1 was assessed to have a , and orders were given to the facility nursing staff to utilize an over the counter until prescribed medication arrived at the facility. Resident #1 was observed to have and in her lower extremities during care. Review of the hospice care orders dated indicated care to be performed weekly by the hospice nurse and as needed by the facility nurse. The note further indicated that a wedge cushion was ordered for positioning and instructions given to the Health and Wellness Director to have Resident #1 turned and repositioned every 2 hours when in bed. Review of the hospice note dated indicated that care was performed on Resident #1 and an old was noted to be dated on the . In an interview with the hospice nurse on at 11:30 AM she stated that she had completed an initial assessment on and Resident #1 had no , or . The nurse stated that she visited Resident #1 again on and the resident's skin was intact, and no observed. The nurse stated that on the visit, she noted that Resident #1 had developed an open area on the , and care supplies/ medications were ordered. The hospice nurse stated that she had communicated to the facility nursing staff and	AN278		

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AN278	Continued From page 20	AN278		

management that the resident must be repositioned every 2 hours when in bed and the [illegible] maintained intact. On [illegible], the hospice nurse performed prescribed [illegible] care and she noted signage above the resident's bed, which instructed care staff to turn and reposition the resident every 2 hours when in bed. The hospice nurse stated that she had followed the facility's policy to complete the "Third Party Provider Collaboration Note" at each visit and she had discussed Resident #1's status and presented the note to the staff nurse on duty in the memory care unit.

Review of the facility electronic nursing notes for Resident #1 dating from readmission on [illegible] indicated that the resident was under hospice care, with a [illegible], but the note did not indicate any [illegible] monitoring. Review of the progress note dated on [illegible] indicated the resident was seen by the hospice nurse and [illegible] care was completed, prior to this progress note there was no documentation about the resident's skin integrity. Review of the progress note dated on [illegible], indicated that the facility nurse had changed Resident #1's [illegible], and no further documentation about any observation of the [illegible] status. The next progress note dated [illegible] indicated that [illegible] care was completed by the hospice nurse and the [illegible] is now assessed as a [illegible], [illegible]. Review of the facility progress notes from [illegible] to [illegible], indicated no documentation of facility nursing monitoring of the [illegible] or description of the [illegible] status and nursing services being provided to the resident.

In an additional interview with the Health and Wellness Director and Executive Director on

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AN278	Continued From page 21 at approximately 12 noon, they provided a copy of an "Open Area Review Flow Sheet" dated on which had been signed by the memory care nurse and hospice nurse. Review of the sheet indicated that on , Resident #1 had developed a , .The sheet indicated care orders were written, along with instruction to turn and reposition the resident every 2 hours when in bed. Additional documentation was provided at the same time, which included "Third Party Provider Collaboration Notes "dated on indicated care was performed on that day by the hospice nurse. This form was signed by the memory care nurse and the hospice nurse. Review of the "Third Party Provider Collaboration Notes" dated on indicated care was completed on Resident #1 and no new changes or , was identified at the time of the visit, again both the memory care nurse and hospice nurse had signed on the note. In an interview with the Executive Director on at 12:15 PM she stated that the facility policy for communication failed because the nursing staff did not verbally communicate to the appropriate management personnel. She stated that completion of a form is not enough, it should always accompany verbal communication. She stated that the Health and Wellness Director had been out of the building from - which may have contributed to the situation. The Executive Director stated that she could not explain why facility care staff had not informed her about Resident #1's change in skin condition starting on with the development of a and why the nursing staff had not thoroughly documented observations of care and services being provided to the resident. The Executive Director stated that she was unaware	AN278		

Agency for Health Care Administration

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AN278	Continued From page 22 that Resident#1's updated Health Assessment had documentation of the [illegible]. Class III	AN278		