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
	AL11965386	A. BUILDING: _____ B. WING _____	08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH	2400 SOUTH CONGRESS AVENUE BOYNTON BEACH, FL 33426

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A 000	Initial Comments An unannounced licensure complaint survey (#2021011598) was conducted on through at Boynton Beach. The facility had a deficiency identified at the time of the survey.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall 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 must notify the resident ' s representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for 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	A 025		

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A 025	Continued From page 1 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. (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 observations, interviews and record reviews, it was determined that the facility failed to ensure residents are adequately supervised while sitting outside on the Memory Care patio areas of the facility (enclosed and non-enclosed area), for 1 out 3 sampled residents known to frequently sit outside in the area. As evidence of Resident #1 being left outside in the patio area on [redacted] for an unidentified amount of time; resulting in the resident being transferred to the hospital and suffering from heat exhaustion, [redacted] and sunburn on the [redacted], arms and abdomen [redacted].	A 025		

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A 025	Continued From page 2 The findings included: Review of the facility's website on , www. _.com/senior-communities-in-florida/ -boynton-beach shows the following. At Boynton Beach, were known for personalized care that weaves each resident's tastes and preferences into daily activities, programming and dining services. Personalization carries over to our team members who develop care plans fully reflective of the individual. We emphasize the value of independence and freedom to make daily choices as fundamental to the well-being of our assisted living residents. From our innovative design and safety features to our specially trained -certified caregivers, Boynton Beach has everything you and your loved ones need to feel safe, happy and right and home. During an interview with Director of Nursing (Staff K) on at 9:25 AM, she stated that the Administrator/Executive Director was currently not available and out of the building; therefore, use was unable to participate in the complaint investigation. Staff K stated she was the designated person in charge of the Memory Care unit. She also confirmed that both Building #1 and #2 are the memory care secured units. She stated residents that reside in these buildings suffer from and require additional supervision. She also identifed Building #1 residents require a higher level of supervision as compared to Buidling #2. The DON was also requested to provide the facility's policy on supervision and/or policy related to supervising the residents within the facility and outside. She was unable to provide a policy.	A 025		

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A 025	Continued From page 3 On . . . . . at 11:35 AM, an interview was conducted with the Regional Clinical , . The Regional Clinical , ... due to the absence of the Administrator assisted with the investigation. At this time, she was requested to provide the Supervision policy for the secured Memory Care Unit; specifically related to the parameters for allowing the , residents to go out onto the open-access patio and courtyard area. She stated the facility did not have a supervision policy at the time of the incident involving Resident #1 on , nor does the facility currently have a Supervision Policy regarding the topic. She was informed that the policy was referenced in the notification of incident submission to the Agency and that we needed to review the documents. However, she stated she didn't have the policy for review as requested by the surveyor. Review of the preliminary Adverse Incident Report submitted by the facility's Administrator to the Agency on . . . . . revealed the following. Resident # 1 on at approximately 2:55 PM, was observed ambulating in hallway in stable condition by Staff A, Certified Nursing Assistant (CNA). At 3:15 PM, Resident # 1 was observed outside in screened patio area by Staff B, CNA, Medication Technician (MT) on duty. Resident # 1 was transferred into community. Nurse on duty, Staff C, Licensed Practical Nurse, (LPN), responded and evaluated resident. At 3:18 PM, 911 activated, MD notified at 3:30 PM. Resident # 1 was transferred to the local hospital Emergency Room (ER). Son made aware. Further review of the facility corrective action plan as of . . . . . submitted by the facility's Administrator noted the following. Exterior doors	A 025		

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A 025	Continued From page 4 were secured from the inside. Memory Care Courtyard Policy was updated to include supervision of all MC residents whenever outside in the courtyard. MC staff in-service on Memory Care Courtyard Policy. Hydration stations maintained on outside patio, accessible to all residents. Staff will continue to encourage adequate hydration throughout the day. The analysis dated . . . . . shows that the resident is an ambulatory, memory care resident. Resident went to sit outside in shaded patio area. Resident was outside for no more than 30 minutes and transferred . . . inside due to apparent change in resident's condition. On . . . . . at 10:00 AM, a tour of the Memory Care Unit, building # 1 was conducted with the facility Director of Nursing, (DON). She stated that this Memory Care Unit mainly housed those residents who have moderate to severe . . . . . and require a higher level of supervision for their acuity levels. She stated there were a total of 8 residents currently residing in building #1 Memory Care Unit (including Resident #1). It was revealed that the exit door (from inside of the facility) to the covered, screen enclosed patio contained a French style door. There was a latch located in the left corner of the approximately 80-inch door. The latch was unlocked at the time of the tour. This enclosed patio area contained a large ceiling fan with patio chairs. Currently, there was a plastic water hydration container on the center wicker table. The hydration station was filled with ice and water. There were cups placed on the table. The screened patio area (enclosed patio) leads out onto the open-air courtyard (patio area #2). Further observations of the second patio area revealed it was not screened and an open area.	A 025		

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A 025	Continued From page 5 The open-air courtyard was observed with lattice style wooden benches and chairs. There was one table observed with a large umbrella that was closed over the table. The courtyard was enclosed by a chain-length fence. On [redacted] at 10:10 AM, an observation and interview was conducted with Resident # 1. She was able to provide her first and last name. She was unable to provide her age, or her current location. When asked why, she looked away and did not answer. She stated that she was never in the hospital. She did not recall any details regarding the incident such as sequence of events that lead to going to the hospital, nor her physical condition when she arrived. She was dressed in slacks and a [redacted] top with ¾ length sleeves. A review of the initial Resident Health Assessment (AHCA 1823 form) completed for Resident #1 dated [redacted], documents the following. The resident suffers from [redacted]. She suffers from generalized [redacted]. Resident # 1 is at risk for elopement and [redacted]. Resident # 1 requires redirection and is alert with [redacted]. She requires supervision and queuing with eating and assistance with ambulation, bathing, [redacted], self-care grooming, toileting, and transferring. Resident # 1 requires daily oversight for observing well-being, observing daily whereabouts and reminders for important tasks. Review of Resident #1's electronic progress notes revealed the following. On [redacted] 3:15 PM, Nurse, writer responded to call for assistance from attending CNA and Nurse on duty. Upon arrival, resident was observed on outside screened patio area, sitting on bench, [redacted]	A 025		

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A 025	Continued From page 6 with minimal response to stimuli. 911 activated and responded to community. Per report from attending staff resident was observed at approximately 2:55 PM sitting in common area in stable condition. Resident was transferred to local hospital for evaluation and treatment. Advanced Nurse Practitioner, (ARNP) and son made aware. On 6:56 PM, return from the hospital accompanied by two persons. Resident alert and oriented with , verbally responsive, no acute distress noted. Private Duty Aide, (PDA) by bedside B/P , 18, Temperature 97.4, Saturation ( ), 100% on room air. ARNP made aware and family Resident is . We will continue to monitor. Skin assessment was done noted multiple to , to upper extremities noted. A review of Resident #1's Care Plan dated was conducted with the Regional Clinical Director. According to the Regional Clinical Director the plan was updated upon the resident's return. At this time, a request was made to review Resident #1's previous Care Plan, the facility stated this was the plan. However, it could not be determined what the previous plan reflected versus the current plan. Further review of the plan failed to indicate any reference to outside activities Resident #1, the methods and steps facility will implement regarding the resident going outside on the patio and any other protective measures implemented. On at 8:55 AM, an interview was conducted with Staff E (CNA/Direct Care Staff). She stated that she was the CNA assigned to work on the 7:00 AM - 3:00 PM to provide care to Resident # 1. She stated that she takes the residents outside for approximately 25-30	A 025		

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A 025	Continued From page 7 minutes. She only has 3 residents (Resident # 1, # 2, and # 3) who enjoy going outside in this building. She says this type of incident has never happened in the past. She stated the patio doors are not always locked, but she makes sure that the residents never go outside without another staff. She says she keeps her . , . . on the residents. On at 9:20 AM, an interview was conducted with Staff A (CNA/Direct Care Staff), the following was revealed. She stated she was on duty on the date of the incident on . . . . She stated she had just been interacting with Resident # 1 in the hallway near her apartment, before she clocked out for the day. She stated at 2:55 PM, she went outside to take the trash out and when she returned, she still saw Resident # 1 in the hallway. She stated she clocked out at 3:00 PM. She says after she left the facility, the Administrator called her and asked her if she had left Resident # 1 outside. She says she advised them that when she left, Resident # 1 was still inside of the building. On at 9:55 AM, an interview was conducted with Staff H (Home Health Aide (HHA). She stated, she provides direct resident care to Resident # 1 and works on the 7:00 AM - 3:00 PM daily. She assists with self-administration of medication in Memory Care Unit, building # 1. She stated that she was not working on . . . . . , the day of the incident. She stated she doesn't normally take the residents outside. She says usually the CNAs go outside with the residents. She stated Resident # 2 and # 3 only go outside currently. She stated Resident # 1 no longer goes outside. On at 9:33 AM, 9:33 AM, an interview	A 025		

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A 025	Continued From page 8 was conducted with the Maintenance Director and the DON. The Maintenance Director was asked about the patio doors in building #1. He stated that the locks were placed on the top of the door in the enclosed patio area #1 of building # 1, that leads to the open patio area (patio area #2) after the incident regarding Resident #1 on . He stated the building was built in 1999 and didn't have any locks on the doors prior to the incident. On at 1:00 PM, a telephone interview was conducted with Resident #1's Durable Power of Attorney and Health Care Surrogate (POA/HCS). He stated Resident #1 enjoyed sitting outside on the patio and has always loved the outdoors. He stated the facility staff in building #1 was aware of Resident#1's desire to sit on the patio routinely. He further stated on , the facility called him immediately after the incident took place. He stated that he informed the Executive Director (ED) that Resident # 1 staying out in the sun so long, could have been catastrophic. He stated he was very concerned that this happened. He stated, the ED informed him that the facility would be making changes to the patio door. He also confirmed that the family provided the facility with a sunscreen-based lotion to apply to Resident #1 due to her desire to be outdoors in the patio area. He was unable to confirm whether the facility had been applying the screen as requested. On at 1:50 PM, a telephone interview was conducted with the second Durable (POA/HCS) for Resident # 1. She stated she never heard from the facility. She stated when her family member told her about what happened; she was very concerned. She stated somebody should have been watching Resident # 1 and not	A 025		

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A 025	Continued From page 9 allowed her to sit in the sun for 30 minutes. On . . . . . at 4:05 PM, an interview was conducted with the Activities Director for both Memory Care Units, building # 1 and building # 2. She stated on 3 days a week she takes Resident # 1 outside daily, approximately 3 times per day. She stated she goes out at 10:00 AM, 1:30 PM, and 3:00 PM. She stated the resident usually stays out from 15-30 minutes. She stated the staff randomly check on her while she is on the covered patio. She stated the resident has sunscreen provided by the resident's family member. She stated on the staff provided the sunscreen to the resident. as the family provides it for regular body lotion. She stated that she was on vacation from - . Although, she was on vacation, the Activities Director stated that she knows the lotion with a sunscreen base was put on the resident as this is a part of the resident's routine morning care. She confirmed that the assigned staff had to cover her position during her absence. However, the facility was not able to identify which person(staff) covered the outside duties with the residents (including sitting on the patio). On . . . . . at 10:00 AM, an interview was conducted with the DON (Staff K). She stated she reinterviewed the direct care staff that were on duty on . She stated that Staff D, the LPN scheduled on duty from 7:00 AM - 3:00 PM in the facility, stated she did recall seeing Resident # 1 on the enclosed screened patio at approximately. 1:30 PM. She could not state how long the Resident remained on the patio through the end of her shift at 3:00 PM.	A 025		

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A 025	Continued From page 10 On . . . . . at 11:00 AM, a telephone interview was conducted with Staff I (Med Technician and Direct Care Staff). Staff I stated, she is assigned to work as a Medication Technician, (Med Tech) on the 11:00 PM - 7:00 AM shift. She stated she heard that the resident had a heat . . . . on the next day when she came to work; she did not work on . . . . . , the date of the incident. She stated her prior observations of Resident #1 on . . . . . , she did not see any red marks or on the resident's nor any . She says it was not easy giving the resident her medication. She also confirmed that the resident likes to sit outside. On an online Google search was conducted on accu-weather for the date of Wednesday, ... According to the website accu-weather shows the temperature: the high at 86 degrees Fahrenheit, (F), and the low temperature at 78 degrees F. The time of the incident was 3:18 PM. On an updated online website search was conducted to obtain a more accurate temperature check for the date of the incident of . . . . . The following temperatures were recorded at the specific times listed: 1. 6:00 AM, high = 81 degrees F., low = 79 degrees F. 2. 12:00 PM, high = 84 degrees F., low = 77 degrees F. 3. 6:00 PM, high = 82 degrees F., low = 81 degrees F. Review of hospital Records for Resident #1 dated on . . . . . at 16:15 (4:15PM) revealed the following. Resident #1 was transferred by (Emergency Medical Services) on to the hospital. History of present illness noted as	A 025		

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A 025	Continued From page 11 heat exhaustion, unresponsive. Patient is from memory care unit was found outside for unknown amount of time. Patient is red sunburn appearance on torso, , , she is diaphoretic and unresponsive. She is shaking and her clothes are wet. Resident sustained the following injuries: left , fluid , left fluid , left medial fluid , left fluid , right open , right fluid . Further review of Resident #1's hospital records revealed a discharged date of to the facility. Review of the discharge notes documented the discharge diagnosis as Acute , , , Heat exposure with . Discharged to Home Health Services. Review of Home Health notes dated revealed Resident #1 was receiving nursing care for to the following: 1. Left , fluid . 2. Left fluid . 3. Left medial fluid . 4. Left fluid . 5. Right , open . 6. Right fluid . Right side of the , 3 small . During further interview with the DON and Regional Clinical , the facility's corrective action plan and the incident reports were discussed. Based on interviews conducted with facility staff and review of facility records, it was determined that the facility was unable to identify the exact amount of time the resident was left outside unattended on . The facility was also unable to identify which staff would have been responsible for overseeing the resident(s) outside in the absence of the Activity Director on , whom routinely escorted Resident	A 025		

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A	Continued From page 12 #1(and other residents) outside in the patio areas (#1 and #2) per interview on at 1:50 PM. The facility staff were also unable to identify within the care plan where the facility addressed the resident's desire to be outside on the patio in a safe and supervised manner. During the investigation, it was also determined that the facility failed to provide sunscreen on the resident as requested by Resident #1's family. The facility staff that worked in building #1, all identified Resident #1 strong desire and frequency to visit the patio areas on a daily basis. Class II	A 025		