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
	AL11964730	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY POINTE TERRACE	1200 ARTHUR STREET HOLLYWOOD, FL 33019

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A 000	Initial Comments Complaint Surveys: CCR #2012006746 - One of three allegations was substantiated. CCR #2012005780 - The allegation was substantiated. Bay Pointe Terrace had licensure deficiencies found at the time of the visit on [redacted] related to the allegations reviewed.	A 000		
A 008 SS=D	58A-5.0181(2) FAC Admissions - Health Assessment (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days prior to the individual ' s admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or [redacted] services required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms of a communicable [redacted] which is likely to be transmitted to other residents or staff; 7. A statement on the day of the examination that, in the opinion of the examining licensed health	A 008		

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A 008	Continued From page 1	A 008		

care provider, the individual ' s needs can be met in an assisted living facility; and
8. The date of the examination, and the name, signature, address, phone number, and license number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state.
(b) A medical examination completed after the resident ' s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, ... 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ <http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/> Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows:
1. The resident ' s licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment.
a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion.
b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider.
c. Omitted information received verbally must be documented in the resident ' s record, including the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided.

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A 008	Continued From page 2 2. The facility administrator, or designee, must complete Section 3 of the form, Services Offered or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the elements in Section 3. This requirement does not apply for residents receiving: a. Extended congregate care (ECC) services in facilities holding an ECC license; b. Services under community living support plans in facilities holding limited mental health licenses; c. Medicaid assistive care services; and d. Medicaid waiver services. (c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual ' s admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823. (d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule. (f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the health assessment. A licensed health care provider may attach a [redacted] order for residents who do not wish [redacted] to be administered in the case of	A 008		

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A 008	Continued From page 3 or (g) A resident placed on a temporary emergency basis by the Department of Children and Family Services pursuant to Section 415.105 or 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility ' s admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that the Health Assessments were complete and up to date for 2 of 6 sampled residents (#3 and #4). The findings are: 1. During a review of the resident records it was noted that resident #3's record contained a Health Assessment that was not signed by the health care provider. In addition, the assessment documented that the resident required medication administration, and the facility does not have licensed nurses 7 days a week. 2. Resident #4's record was reviewed. The Health Assessment was signed by the health care provider, but there was no date of the signature. In addition, there was no entry for the mode of medication administration. The administrator was interviewed on at	A 008		

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A 008	Continued From page 4 3:15 p.m. and no additional information was provided. Class III	A 008		
A 010 SS=D	58A-5.0181(4) FAC Admissions - Continued Residency (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (e) of this subsection, criteria for continued residency in any licensed facility shall be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a face-to-face medical examination by a licensed health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule. The form must be completed in accordance with that paragraph. After the effective date of this rule, providers shall have up to 12 months to comply with this requirement. (a) The resident may be bedridden for up to 7 consecutive days. (b) A resident requiring care of a pressure ... may be retained provided that: 1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a licensed health care provider, or the resident contracts directly with a licensed home health agency or a nurse to provide care; 2. The condition is documented in the resident ' s record; and 3. If the resident ' s condition fails to improve within 30 days, as documented by a licensed health care provider, the resident shall be	A 010		

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A 010	Continued From page 5 discharged from the facility. (c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to the services of a licensed hospice which coordinates and ensures the provision of any additional care and services that may be needed; 2. Continued residency is agreeable to the resident and the facility; 3. An interdisciplinary care plan is developed and implemented by a licensed hospice in consultation with the facility. Facility staff may provide any nursing service permitted under the facility ' s license and total help with the activities of daily living; and 4. Documentation of the requirements of this paragraph is maintained in the resident ' s file. (d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility. (e) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. (5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident ' s needs, as determined by the facility administrator or licensed health care provider, the resident shall be discharged in accordance with Section 429.28(1), F.S. This Statute or Rule is not met as evidenced by: Based on observations, interviews and record	A 010		

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A 010	Continued From page 6 reviews, the facility did retain a resident who no longer met the criteria for 1 of 6 sampled residents (resident #3). The findings are: Resident #3 was observed on [redacted] at 10:45 a.m. in a wheelchair. The resident did not respond to questions. The administrator was present and upon being interviewed said the resident is able to walk, but her joints are stiff in the morning. The med tech was interviewed on [redacted] at approximately 11:45 a.m. and said the resident does not walk much because she will [redacted] The resident ' s record was reviewed. The resident was admitted on [redacted]. The Health Assessment documented that the resident had [redacted], Non [redacted] Dependent [redacted], High [redacted] and [redacted] The Health Assessment also documented that the resident ambulates with assistance, transfers with assistance, bathing and dressing with assistance, is independent with eating and needs medication administration. The Health Assessment had no signature of the health care provider. On [redacted] at 12:20 p.m., the resident was observed being fed lunch by a staff member. On [redacted] at 2:32 p.m., the resident ' s C.N.A was interviewed. She said the resident has to be fed every meal. She said the resident requires total assistance for bathing and dressing as well. The administrator was interviewed again at [redacted] at 3:15 p.m. No additional information was provided. Class III	A 010		

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A 025 SS=D	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, 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 individual. (c) 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; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to document changes in condition and failed to ensure that residents received the appropriate supervision for 2 of 6 sampled residents (#1 and #2).	A 025		

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A 025	Continued From page 8 The findings are: Resident #1 was admitted to the facility on . The record documented that the resident's son was the Power of Attorney (POA). The Health Assessment documented that the resident had ... Dependent ... and The Health Assessment documented that the resident ambulated independently and was agitated at times. The resident required assistance with bathing, dressing, toileting and . The resident required supervision for eating and was independent with transfers. On , the day of admission, the resident's medications were verified with the physician and included ... 81mg, Benezepril 10mg, ... 0.25mg twice a day and ... 0.5mg twice a day. On the "move in communication form" the resident was marked as "wanders". The incident reports were reviewed and documented that on . the resident could not be located in the building although a search was done of the premises and surrounding buildings, however, in the meantime the police found the resident on the adjacent street and returned the resident to the facility. The progress notes document that the family and physician were notified. When the resident was returned to the facility, a one to one sitter was placed with the resident. On : the psychiatrist evaluated the resident and documented that the resident was . excited, , inappropriate and illogical. The evaluation also documented that the resident was exit seeking. The	A 025		

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A 025	Continued From page 9	A 025		

psychiatrist discontinued the previous order for Risperdal 3mg twice a day and ordered Risperdal 1 mg at night.
On 05/0 psychiatrist documented that the resident had dementia, insight and moderately impaired and short term memory.

The resident's record also contained a letter from the facility documenting that the resident's needs could not be met and a 45 day notice is being issued. The letter was dated 5/14 letter was addressed to the resident's daughter and son and included the information that the resident needs to be in the locked unit and that the spouse was acting aggressively towards the resident. On 06/0 was a note that documented the resident was hospitalized and the son and the daughter were notified.

Resident #2, spouse of resident #1, was admitted to the facility 04/1 Health Assessment documented that the resident had Alzhei

Insulin Diabetes Anxiety.
resident ambulated independently and was confused times. The resident required assistance with activities of daily living and with medications. The medications at the time of admission were reviewed and did not include Risperdal Zoloft. April was reviewed and documented that on 04/2 resident began receiving Risperdal mg every night. On 04/2 resident started receiving Zoloft every day.

The progress notes were reviewed and documented that on 04/2 resident was evaluated by the psychiatrist. He discontinued the Lexapro ordered Zoloft Risperdal.

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A 025	Continued From page 10 The record did not contain any record of any behaviors that would necessitate the use of the [redacted] medications. Further review of the progress notes document that on [redacted] a family meeting was conducted with the resident' s son. A 45 day notice was issued for both residents, due to the facility could no longer meet the residents' needs. There was a progress note dated [redacted] that the psychiatrist discontinued the [redacted]. On [redacted] the resident was discharged to the family, with medications and belongings. The administrator was interviewed on [redacted] at 3:14 p.m. She said that resident #1 pulled an emergency alarm two times on [redacted]. She said this happened in the evening, and the evening staff checked and secured all doors. She said the resident was accounted for and re-directed at that time. She said that approximately a half hour later that staff did rounds and were unable to locate the resident. Staff thoroughly searched the premises and surrounding building. She said that the police returned the resident after finding him on the next street a short time later. She said the facility ' s policy is to notify law enforcement within 45 minutes, after the grounds have been searched. There was documentation that the family and the physician were notified. A one to one sitter was placed with the resident for the night. During further interview with the administrator, she said that the resident and his wife were admitted to a [redacted] the main part of the facility and not in the locked unit because the family wanted the residents together, and she had been told the resident was not in a locked unit at the previous facility. She later found out that the	A 025		

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A 025	Continued From page 11 resident had behavior issues. She said that the residents had four children, and that she informed them to agree on one family member to be responsible for communication. The administrator said that the son and daughter were the Power of Attorney, but the son lived locally and visited frequently. The administrator said she spoke with the family members and had meetings, but was unable to locate the documentation. One of the issues was that the resident' s wife would become aggressive with the resident and the staff were concerned that the resident would be injured. The administrator said that both residents had a history of issues. She said that resident #1 was not sleeping well and was found disrobing. The resident's spouse was also acting aggressive towards her husband. The administrator was unable to provide any documentation of these behaviors, other than the 45 day notice. The records did not contain any evidence of documentation of a change in behaviors prior to the increase for resident #1 and no documentation of any behaviors prior to the use of the for resident #2. Class III	A 025		
A 030 SS=G	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the	A 030		

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admission package provided pursuant to Rule 58A-5.0181, F.A.C.
(b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
(c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.
(d) The statewide toll-free telephone number of the Florida ..... Hotline " 1(800)9€ . or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s ..... and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.
(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be

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A 030	Continued From page 13	A 030		

responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.
(g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.
(h) Pursuant to Section 429.41, F.S., the use of physical [redacted] shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical [redacted]

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from [redacted] and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate

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
	AL11964730	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY POINTE TERRACE	1200 ARTHUR STREET HOLLYWOOD, FL 33019

(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 030	Continued From page 14	A 030		

living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a . . his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.
(k) At least 45 days ' notice of relocation or termination of residency from the facility unless,

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	AL11964730	A. BUILDING _____ B. WING _____	

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A 030	Continued From page 15	A 030		

for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

This Statute or Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure that residents were treated with dignity for 1 of 6 sampled residents (#6) and the facility failed to ensure that residents were free from for 2 of 6 sampled residents (#4 and #5).

The findings are:

1. A tour was conducted of the secured unit on

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A 030	Continued From page 16 at 10:45 a.m. with the administrator. There were two residents observed with trunk (resident #4 and resident #5). The administrator said that both residents were receiving hospice services. Resident #4 was observed rocking back and forth in the wheelchair and was whistling. The resident did not respond to questions and did not respond when asked to remove the lap buddy. Resident #5 was observed in a gerichair with a lap tray in place. The resident did not respond when addressed, and did not remove the tray when asked. The resident was sitting up straight in the chair, holding on to the lap tray. Record review for resident #4 and #5 revealed that the residents are . The administrator was interviewed on at 3:15 p.m. and no additional information was provided. 2. Resident #6 was observed at lunch in the main dining , seated at table 1 with two other residents. One of the residents was being fed by staff. Resident #6's meal was observed covered and placed on the table to the side of the placemat. The resident was observed holding on to the table while watching the staff member feed the other resident at the table. The administrator was interviewed on and no additional information was provided. Class II	A 030		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

2012

Administrator
Bay Pointe Terrace
1200 Arthur Street
Hollywood, FL 33019

Re: CCR #2012005780 and CCR# 2012006746

Dear Administrator:

This letter reports the findings of two complaint surveys conducted on 2012 by a representative of this office. Attached is the provider's copy of the State Form 3020, which indicates the deficiencies identified on the day of the visit. Section 408.811(4), Florida Statutes, requires you correct these deficiencies within **thirty (30) days** of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **2012** to verify the necessary corrections are in place to correct the deficiencies identified on your survey.

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 this agency's representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

A. C. Boyles, HFE Supervisor

for Arlene Mayo-Davis
Field Office Manager

AMD/hl
Enclosure

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