STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942705	
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brighton Gardens Of Boca Raton	6347 Via De Sonrisa Del Sur Boca Raton, FL 33433	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= G
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - N277 - 58a-5.031(2) Fac - Lns - Resident Care Standards S-S= G

Specific Tag Findings:

0000-Initial Comments
An unannounced licensure complaint survey, CCR#2014006587, was conducted on through at Brighton Gardens of Boca Raton. The facility had deficiencies found at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on observation, interview, and record review, the facility failed to ensure the Resident Health Assessment form (AHCA form 1823) assessment form was complete with all the required information, for 3 of 3 residents reviewed (Resident #1, #2, #3).

The findings include:

A complaint inspection was conducted on and during record review the following was found:

a) Resident #2 was admitted on with diagnosis of and He was admitted under Hospice services on and moved to the memory care unit on . His AHCA form 1823 assessment dated , did not indicate he required and was receiving Hospice services. It lacked information regarding his physical and sensory limitations, or behavioral status, service requirements, and any special precautions necessary. Under activities of daily living, his eating abilities were left blank. Review of his medical record revealed he had problems with eating and Hospice was treating a on his right . The was observed by the surveyor (an Registered Nurse) on at 10:30 AM. The AHCA form 1823 did not indicate the resident had a It was also noted the AHCA form did not contain a contact person and telephone number, or weight.

b) Resident #3 was readmitted to the facility on from the hospital. His AHCA form 1823 assessment dated , lacked the required information about the medical certification. It contained a physician's signature only. The printed name, license number, address, and telephone number were missing. The contact person, and height and weight were left blank.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942705	09/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brighton Gardens Of Boca Raton	6347 Via De Sonrisa Del Sur Boca Raton, FL 33433	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

c) Resident #1 was admitted on . Her AHCA form 1823 assessment dated lacked the required information about the medical certification. It contained a physician's signature and license number only. The printed name, address, and telephone number were missing.

The AHCA form 1823 of Resident's #1, #2, and #3 were reviewed by the Health Care Coordinator and the Executive Administrator in the presence of the surveyor on . Both validated the forms were incomplete as described.

Class III

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on interview, and record review, the facility failed to ensure a resident was reassessed upon significant health changes and the results documented on a AHCA form 1823 to ensure a resident met the criteria for continued residency and that the facility was able to provide the appropriate level of care and services. As evidence of the facility failure to ensure a plan of care for facility-acquired was issued by a health care provider to maintain continued residency, for 1 of 3 residents' records reviewed (Resident #1).

The findings include:

Resident #1 was admitted to the facility on move-in date of with diagnosis of , Parkinson's, and . She was discharged to the hospital on when she developed symptoms of a of 102.4 and shivering.

Her AHCA form 1823 dated indicated she required assistance with activities of daily living, including toileting, and total assistance for bathing. She was noted to be alert and oriented to person and place, with intermittent Under service requirements" documentation revealed TNR - Mon. Wed. Fri", as the resident was receiving . It also stated she needed "medication management", "Calazanine cream to and areas", and "skin prep to bony prominences." Under special precautions, documentation revealed a special mattress, "cushion relieving pressure to w/c, tab alarm to bed and chair for safety, and offload heels while in bed."

Further review of her medical record revealed on admission, Physician #A who cared for the resident and her husband in their past, was indicated by the family to oversee her care. Her demographic sheet contained the name, address, and phone number of this physician.

Record review also revealed the resident was of bowel and and wore briefs. She was toileted before meals, bedtime, and as needed per interview with staff. She spent the majority of her day

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942705	09/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brighton Gardens Of Boca Raton	6347 Via De Sonrisa Del Sur Boca Raton, FL 33433	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

in the memory unit. She utilized a wheelchair during the day.

Review of the progress notes, including handwritten and electronic records, revealed the following:

a) 2 PM "...skin warm,dry, multiple discolorations on bilat arms... blanchable redness ... inc. of B&B, needs x 1 with ADL's, meds will be provided by family (husband), oriented to facility."

b) PM (no hour documented) - "Per son (name) order same until next week to be followed by in-house doctor...Son made aware resident is covered by (name inserted) insurance...not accepted by (name) physician #D and (name) physician #E", who are doctors who care for residents at the assisted living facility. The note continues, "Son will try to take them to physician #A or paid to be transported until insurance changed to medicare."

c) 8:30 AM - "Wellness nurse called to direct care manager (DCM), resident in bed, and combative with DCM while attempting to provide AM care...resident noted with an on her right inner lower arm...first aide applied...resident was brought to med her AM medications and resident became agitated and refused medications...message left for son and physician #A to notify."

There was no evidence found the facility investigated the or put measures in place for prevention.

d) 8 PM - "Care manager reported while doing PM care she noticed resident had an on L lower extremity...first aid done...bandaid apply...family member and physician #A will notified."

There was evidence the facility investigated the , found on a report dated , but did not determine a cause or implement preventative measures.

e) 11 AM - "Called Physician #A's office to request order for ..waiting for order to be faxed."

f) 7 PM - "Bandaid to left leg changed and cleansed, new bandaid apply"

g) 2 PM - "Drsg to L leg intact."

h) 6 AM - "L leg dressing intact."

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942705	
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brighton Gardens Of Boca Raton	6347 Via De Sonrisa Del Sur Boca Raton, FL 33433	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

i) "4 PM returned message on answering machine from physician #A (name) office regarding INR results, order 3 mg one po qd."

j) 10:52 AM - Nurse from physician #A regarding INR explained that we need an order to redraw NR, nurse stated physician #A will no longer be the resident's doctor and new doctor needs to order NR, informed physician #A's nurse that family must be notified in order to make they find a new doctor, she says they will notify family, wellness nurse will also notified husband."

k) 21:34 - "New order received via fax. INR in am no s/s of distress noted."

l) 06:34 - "Resident in bed combative with AM care, Assisted DCM to change adult diaper. Dressing noted to area with redness. House barrier cream applied."

m) 19:41 - INR result received. INR 1.76 Physician #A notified. New order obtained. Kept same dose 3 mg po daily. Rechecked INR in 1 week. No discomfort noted. No noted. Will continue to monitor res."

n) 10 AM - "Reported by CM that resident had red (illegible) area to left Assessed resident skin condition and observed nonblanchable redness to left applied barrier cream and cushion to wheelchair, instructed to reposition resident Q 2 hours..."

o) 7:30 PM - "Called by DCM to check on resident left side of / ". The progress not was not completed nor signed and 6.5 spaces left blank with a gap before next entry written.

p) 8 AM - "resident in bed, checked resident skin - noted to right and red area to left. Cleanse area with NS applied dressing to both areas. Physician #A called, left message with nurse, husband notified."

q) 8 PM - "Drsg in place and intact to

r) 8 AM - "Called by care manager to resident's dressings from previous day were removed due to soiled (illegible), cleansed areas with NS - open area noted to right and left bony areas, applied cream dry protective dressing, Physician's #A resident's PCP called again, asked for care order, left message with (name) - waiting for reply. Family notified. Cushion on the wheelchair in use, care manager (illegible) instructed to change resident routine Q 1 hour. Resident (illegible) non compliant with repositioning, P 86, R 18, T 98.2, of B&B needs x 2 for toileting and transfer."

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942705	09/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brighton Gardens Of Boca Raton	6347 Via De Sonrisa Del Sur Boca Raton, FL 33433	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

s) 8 PM - "Res been observed, sleeping in bed (illegible) in bed. Resp even and unlabored. Clean & changed by care manager + repositioned Q 2 hours. DRSG in place and dry, no complaints noted, will continue to monitor res. Left message Physician #A regarding care order waiting."

t) 12:30 - "Spoke with son (name) concerning PCP, stated that they are in process of getting Medicare for his mother and that by next week they will have a PCP."

u) 14:55 - "Late entry for 5:30 PM - Physician #A contacted regarding care order for to office staff informed that doctor will no longer follow resident or give orders for resident because her thirty day notice is up. When ask when it was giving Rep responded that family was given 30 day notice since Husband was called to wellness regarding this situation but says he does not remember if he received notice or not, per conversation between nurse and husband the family has not found a new pcp for the resident because they're in the middle of changing her medical coverage when ask husband says that the residents (name inserted) coverage was terminated on Nurse suggested taking resident to care center, nurse contacted (name) care center to obtain info for the family regarding how much care would cost. care staff instructed to call back in the morning and speak with Donna regarding payment, ins, and appointment. Staff has been instructed to keep resident in bed pressure off the and turning every hours."

v) 15:18 - "Transferred to (name) hospital; Reason for transfer: Elevated temp (102.4), shivering and , Condition of Resident Upon Transfer: awake, alert, and responsive; Vital signs: RR 20. Pulse 89, Temp 102.4; Transportation : AMR; Notifications: Son was made aware by HCC."

There was no evidence found regarding treatments given to the resident were ordered by a licensed practitioner. Therefore, there was no plan of care issued by a health care provider for Resident #1. This included the use, application, removal, reapplication, and monitoring of the dressings, as well as the dressings and treatments applied to the of the arm and leg.

In addition, the resident's skin condition worsened. An interview was conducted with the facility's Licensed Practical Nurse (LPN) who cared for Resident #1 on at 2:40 PM. She described making an entry in the medical record after viewing the on but decided she was unable to complete the progress note. She stated she was concerned how to describe the area, the area presented "black" in color, and she wanted the Registered Nurse (RN) to view the site. She verbally described the area as "golfball" size. She indicated she did not know how to stage the in the presence of "black" color presentation. She indicated she informed the RN by telephone and by written note. She stated the resident did not have a physician to care for her skin concerns, only orders and monitoring, so she was not able to inform a physician about the area and obtain orders or a plan of care,

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942705	09/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brighton Gardens Of Boca Raton	6347 Via De Sonrisa Del Sur Boca Raton, FL 33433	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

and management was aware.

An interview was conducted on at 3:12 PM, with the care manager assigned to Resident #1 on and ongoing. She expressed on she observed on the right and left and reported the areas to the nurse. She stated the resident did not have a cushion in her chair and a towel was used on the seat. She stated she observed on the on the right and left were open areas and a nurse applied treatment to each . A cushion was then provided for the resident in her chair. She expressed on the dressings came off and new ones were applied by the nurse. She stated on she spoke to the RN about the areas. She described she took the resident to the memory unit for the day per the resident's normal routine, and was called every 30 minutes to return to the unit to reposition the resident. She stated on she was instructed to keep the resident in bed for the day. She stated she fed her lunch in her , the resident did not want to eat, and she noticed a change in the resident. She stated the resident had an elevated temperature, was shivering, and was later sent to the hospital.

An interview was conducted on at 3:42 PM, with the Executive Director. He expressed he was not made aware of the skin issues or lack of physician services for the resident, until after she was discharged to the hospital. He was made aware by the resident's son on . He validated the facility allowed a resident to reside in the facility with in the absence of a plan of care directed and ordered by a physician. It was also acknowledged that the facility failed to reassess the resident upon aforementioned health changes to ensure the resident met the criteria for continued residency and that the facility could met the care needs (including care)of the resident .

(See A0025 and N277)

Class II

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942705	09/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brighton Gardens Of Boca Raton	6347 Via De Sonrisa Del Sur Boca Raton, FL 33433	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on interview and record review, the facility failed to provide appropriate care and services to meet the needs of 1 of 3 residents (Resident #1) while residing in the facility.

The findings include:

Resident #1 was admitted to the facility on , move-in date of with diagnosis of , Parkinson's, and . She was discharged to the hospital on , due to a change in her condition.

Her AHCA form 1823 assessment form dated indicated she required assistance with activities of daily living, including toileting, and total assistance for bathing. She was noted to be alert and oriented to person and place, with intermittent . Under service requirements" documentation revealed INR - Mon. Wed. Fri", as the resident was receiving . It also stated she needed "medication management", "Calazanine cream to and areas", and "skin prep to bony prominences." Under special precautions, documentation revealed a special mattress, "cushion relieving pressure to w/c, tab alarm to bed and chair for safety, and offload heels while in bed." The contact person noted on the form was a staff member of the facility. The medical certification indicating the physician #C who completed the form, lacked required information .

Further review of her medical record revealed on admission, a certain physician #A who cared for the resident and her husband in their past, was indicated by the family to oversee her care. Her demographic sheet contained the name, address, and phone number of this physician. Her demographic sheet also revealed her son as her responsible party. She did not have a legal power of attorney in place until after her discharge to the hospital on . Her husband was also admitted to the facility on move-in date of and they resided together. Her physician's order sheet dated documents "self" as a responsible party.

She was admitted to the facility from a skilled nursing facility. A list of medications she was receiving there, was provided. She was under the care and services of a different physician #B at the skilled nursing facility.

A nursing progress note indicated on the family was going to provide the medications from a local pharmacy. The resident had been receiving the following:

250 mg one tablet by mouth at bedtime, locor 20 mg one tablet by mouth at bedtime,

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942705	09/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brighton Gardens Of Boca Raton	6347 Via De Sonrisa Del Sur Boca Raton, FL 33433	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

10 mg one tablet by mouth at bedtime, Elavil 2.5 mg one tablet by mouth at bedtime, 1000mcg one tablet by mouth daily, 3.5 mg one tablet by mouth daily which was changed to 3 mg daily by the physician on mg by mouth three times daily, Metroprolol 2.5 mg by mouth twice daily, and 0.1 mg by mouth three times daily.

The record revealed on a Prothrombin time test for monitoring which indicates the time it takes the to clot and required when receiving was drawn and the results were reported to the physician. On another was drawn and the results were 35.5 which was high in the range of 9.9 to 14.0; and an INR (test for monitoring) result of 2.99 which was normal in the range of 0.00-3.00. The facility notified the physician by telephone of the results and received new orders via answering machine from his office to decrease the to 3 mg by mouth daily from 3.5 mg. The physician ordered another INR on The lab was drawn on and indicated 20.9 which was high in the range noted above; and INR 1.76 which was in the normal range. The physician was notified and ordered to keep the dose the same and recheck the INR level in one week. Although, the resident received INR monitoring, the frequency did not reflect Monday, Wednesday, and Friday, as outlined on the 1823.

Further record review revealed the resident was of bowel and and wore briefs. She was toileted before meals, bedtime, and as needed per interview with staff. She spent the majority of her day in the memory unit.

Review of the progress notes, including handwritten and electronic records, revealed the following:

a) 2 PM "...skin warm,dry, multiple discolorations on bilat arms... blanchable redness inc. of B&B, needs x 1 with ADL's, meds will be provided by family (husband), oriented to facility."

b) PM (no hour documented) - "Per son (name) order same until next week to be followed by in-house doctor...Son made aware resident is covered by (name inserted) insurance...not accepted by (name) physician #D and (name) physician #E", who are doctors who care for residents at the assisted living facility. The note continues, "Son will try to take them to physician #A or paid to be transported until insurance changed to medicare."

c) 8:30 AM - "Wellness nurse called to direct care manager (DCM), resident in bed, and combative with DCM while attempting to provide am care...resident noted with an on her right inner lower arm...first aide applied...resident was brought to med her am medications and resident became agitated and refused medications...message left for son and physician #A to notify."

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942705	09/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brighton Gardens Of Boca Raton	6347 Via De Sonrisa Del Sur Boca Raton, FL 33433	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

There was no evidence found the facility investigated the cause of the or put measures in place for prevention.

d) 8 PM - "Care manager reported while doing PM care she noticed resident had an on L lower extremity...first aid done...bandaid apply...family member and physician #A will notified."

There was evidence the facility investigated the found on a report dated but did not determine a cause or implement preventative measures.

e) 11 AM - "Called Physician #A's office to request order for ..waiting for order to be faxed."

f) 7 PM - "Bandaid to left leg changed and cleansed, new bandaid apply"

g) 2 PM - "Drsg to L leg intact."

h) 6 AM - "L leg dressing intact."

i) "4 PM returned message on answering machine from physician #A (name) office regarding INR results, order 3 mg one po qd."

j) 10:52 AM - Nurse from physician #A regarding INR explained that we need an order to redraw NR, nurse stated physician #A will no longer be resident doctor and new doctor needs to order NR, informed physician #A's nurse that family must be notified in order to make they find a new doctor, she says they will notify family, wellness nurse will also notified husband."

k) 21:34 - "New order received via fax. INR in am no s/s of distress noted."

l) 06:34 - "Resident in bed combative with AM care, Assisted DCM to change adult diaper. Dressing noted to area with redness. House barrier cream applied."

m) 19:41 - INR result received. INR 1.76 Physician #A notified. New order obtained. Kept same dose 3 mg po daily. Rechecked INR in 1 week. No discomfort noted. No noted. Will continue to monitor res."

n) 10 AM - "Reported by CM that resident had red (illegible) area to left Assessed resident skin condition and observed nonblanchable redness to left applied barrier cream and

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942705	09/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brighton Gardens Of Boca Raton	6347 Via De Sonrisa Del Sur Boca Raton, FL 33433	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

cushion to wheelchair, instructed to reposition resident Q 2 hours..."

o) 7:30 PM - "Called by DCM to check on resident left side of / ". The progress not was not completed nor signed and 6.5 spaces left blank with a gap before next entry written.

p) 8 AM - "resident in bed, checked resident skin - noted to right and red area to left. Cleanse area with NS applied dressing to both areas. Physician #A called, left message with nurse, husband notified."

q) 8 PM - "Drsg in place and intact to

r) 8 AM - "Called by care manager to resident's dressings from previous day were removed due to soiled (illegible), cleansed areas with NS - open area noted to right and left bony areas, applied cream dry protective dressing, Physician's #A resident's PCP called again, asked for care order, left message with (name) - waiting for reply. Family notified. Cushion on the wheelchair in use, care manager (illegible) instructed to change resident routine Q 1 hour. Resident (illegible) non compliant with repositioning, P 86, R 18, T 98.2, of B&B needs x 2 for toileting and transfer."

s) 8 PM - "Res been observed, sleeping in bed (illegible) in bed. Resp even and unlabored. Clean & changed by care manager + repositioned Q 2 hours. DRSG in place and dry, no complaints noted, will continue to monitor res. Left message Physician #A regarding care order waiting."

t) 12:30 - "Spoke with son (name) concerning PCP, stated that they are in process of getting Medicare for his mother and that by next week they will have a PCP."

u) 14:55 - "Late entry for 5:30 PM - Physician #A contacted regarding woundcare order for to office staff informed that doctor will no longer follow resident or give orders for resident because her thirty day notice is up. When ask when it was giving Rep responded that family was given 30 day notice since Husband was called to wellness regarding this situation but says he does not remember if he received notice or not, per conversation between nurse and husband the family has not found a new pcp for the resident because they're in the middle of changing her medical coverage when ask husband says that the residents (name inserted) coverage was terminated on Nurse suggested taking resident to woundcare center nurse contacted (name) woundcare center to obtain info for the family regarding how much woundcare would cost. Woundcare staff instructed to call back in the morning and speak with Donna regarding payment, ins, and appointment. Staff has been instructed to keep resident in bed pressure off the and turning every hours."

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942705	09/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brighton Gardens Of Boca Raton	6347 Via De Sonrisa Del Sur Boca Raton, FL 33433	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

v) 15:18 - "Transferred to (name) hospital; Reason for transfer: Elevated temp (102.4), shivering and Condition of Resident Upon Transfer: awake, alert, and responsive; Vital signs: RR 20. Pulse 89, Temp 102.4; Transportation : AMR; Notifications: Son was made aware by HCC."

There was no evidence found regarding treatments given to the resident were ordered by a licensed practitioner. This included the use, application, removal, reapplication, and monitoring of the dressings, as well as the dressings and treatments applied to the of the arm and leg. There was no evidence found the on the arm or leg were being monitored for healing progress and the appearance of the sites evaluated. There was no evidence found the resident's heels were offloaded as stated on the AHCA form 1823. There was no evidence found that skin prep to bony prominences on the resident, was applied, as stated on her AHCA form 1823. There was no evidence found the resident's son, her responsible party, was notified about the on the left on nor notified on about the condition of the right The husband was notified on However, the son was documented as the responsible party. An interview with the son was conducted on at 8:21 AM. The son expressed he was not made aware of skin concerns until her transfer to the hospital on

An interview was conducted with the Licensed Practical Nurse (LPN) who cared for Resident #1 on at 2:40 PM. She described making an entry in the medical record after viewing the on but decided she was unable to complete the progress note. (See above note date at 7:30 PM). She stated she was concerned how to describe the area, the area presented "black" in color, and she wanted the Registered Nurse (RN) to view the site. She verbally described the area as "golfball" size. She indicated she did not know how to stage the in the presence of "black" color presentation. She indicated she informed the RN by telephone and by written note. She stated the resident did not have a physician to care for her skin concerns, only orders and monitoring, so she was not able to inform a physician about the area, and management was aware. She stated the skin on the resident's legs was clear on

An interview was conducted on at 3:12 PM, with the care manager assigned to Resident #1 on and ongoing. She expressed on she observed on the right and left and reported the areas to the nurse. She stated the resident did not have a cushion in her chair and a towel was used on the seat. She stated she observed on the on the right and left were open areas and a nurse applied treatment to each A cushion was then provided for the resident in her chair. She expressed on the dressings came off and new ones were applied by the nurse. She stated on she spoke to the RN about the areas. She described she took the resident to the memory unit for the day per the resident's normal routine, and was called every 30 minutes to return to the unit to reposition the resident. She stated on she was instructed to

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942705	09/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brighton Gardens Of Boca Raton	6347 Via De Sonrisa Del Sur Boca Raton, FL 33433	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

keep the resident in bed for the day. She stated she fed her lunch in her the resident did not want to eat, and she noticed a change in the resident. She stated the resident had an elevated temperature, was shivering, and was later sent to the hospital.

An interview was conducted on at 3:42 PM, with the Executive Director. He expressed he was not made aware of the skin issues or lack of physician services for the resident, until after she was discharged to the hospital. He was made aware by the resident's son on He validated the facility did not provide appropriate care and services to meet the resident's needs, and staff were disciplined, including terminations.

An interview was conducted on at 8:43 AM, with the former Associate Executive Director, who was employed at the time of the resident's stay. He expressed the resident did not have a physician in place, her insurance coverage ended the family was trying to arrange Medicare, but it had not been arranged. He expressed the resident developed a that worsened and she was sent to the hospital.

Review of the hospital records when the resident was transferred on indicated she was admitted and treated for ischael This was validated in her hospital discharge summary, dated She underwent a debridement of the on The report, dated documented under Post Diagnosis, Ischeal Under Procedures Performed, documentation revealed, Debridement of Ischael x 2".

(See A 008, A 010 and N277).
Class II

N277-LNS - Resident Care Standards 58A-5.031(2) FAC
Based on interview and record review, the facility failed to ensure Limited Nursing Services (LNS) for facility-acquired were delivered under the order of an authorized health care provider, for 1 of 3 residents reviewed (Resident #1), and the areas worsened.

The findings include:

Resident #1 was admitted to the facility on move-in date of with diagnosis of Parkinson's, and She was discharged to the hospital on Her AHCA form 1823 assessment form, dated indicated she required assistance with activities of daily living, including toileting, and total assistance for bathing. She was noted to be alert and oriented

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942705	09/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brighton Gardens Of Boca Raton	6347 Via De Sonrisa Del Sur Boca Raton, FL 33433	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

to person and place, with intermittent . Under service requirements" documentation revealed TNR - Mon. Wed. Fri", as the resident was receiving . It also stated she needed "medication management", "Calazanine cream to and areas", and "skin prep to bony prominences." Under special precautions, documentation revealed a special mattress, "cushion relieving pressure to w/c, tab alarm to bed and chair for safety, and offload heels while in bed." The medical certification indicating the physician #C who completed the form, lacked required information (See A008).

Her demographic sheet contained the name, address, and phone number of the physician assigned by the family to care for her post admission, Physician #A.

Further record review revealed the resident was of bowel and and wore briefs. She was toileted before meals, bedtime, and as needed per interview with staff. She spent the majority of her day in the memory unit.

Review of the progress notes, including handwritten and electronic records, revealed the following:

a) 2 PM "...skin warm,dry, multiple discolorations on bilat arms... blanchable redness ...inc. of B&B, needs x 1 with ADL's, meds will be provided by family (husband), oriented to facility."

b) PM (no hour documented) - "Per son (name) order same until next week to be followed by in-house doctor...Son made aware resident is covered by (name inserted) insurance...not accepted by (name) physician #D and (name) physician #E", who are doctors who care for residents at the assisted living facility. The note continues, "Son will try to take them to physician #A or paid to be transported until insurance changed to medicare."

c) 8:30 AM - "Wellness nurse called to direct care manager (DCM), resident in bed, and combative with DCM while attempting to provide am care...resident noted with an on her right inner lower arm...first aide applied...resident was brought to med her am medications and resident became agitated and refused medications...message left for son and physician #A to notify."

There was no evidence found the facility investigated the cause of the or put measures in place for prevention.

d) 8 PM - "Care manager reported while doing PM care she noticed resident had an on L lower extremity...first aid done...bandaid apply...family member and physician #A will notified."

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There was evidence the facility investigated the found on a report dated but did not determine a cause or implement preventative measures.

e) 11 AM - "Called Physician #A's office to request order for ..waiting for order to be faxed."

f) 7 PM - "Bandaid to left leg changed and cleansed, new bandaid apply"

g) 2 PM - "Drsg to L leg intact."

h) 6 AM - "L leg dressing intact."

i) "4 PM returned message on answering machine from physician #A (name) office regarding INR results, order 3 mg one po qd."

j) 10:52 AM - Nurse from physician #A regarding INR explained that we need an order to redraw NR, nurse stated physician #A will no longer be resident doctor and new doctor needs to order NR, informed physician #A's nurse that family must be notified in order to make they find a new doctor, she says they will notify family, wellness nurse will also notified husband."

k) 21:34 - "New order received via fax. INR in am no s/s of distress noted."

l) 06:34 - "Resident in bed combative with AM care, Assisted DCM to change adult diaper. Dressing noted to area with redness. House barrier cream applied."

m) 19:41 - INR result received. INR 1.76 Physician #A notified. New order obtained. Keept same dose 3 mg po daily. Rechecked INR in 1 week. No discomfort noted. No noted. Will continue to monitor res."

n) 10 AM - "Reported by CM that resident had red (illegible) area to left Assessed resident skin condition and observed nonblanchable redness to left applied barrier cream and cushion to wheelchair, instructed to reposition resident Q 2 hours..."

o) 7:30 PM - "Called by DCM to check on resident left side of / ". The progress not was not completed nor signed and 6.5 spaces left blank with a gap before next entry written.

p) 8 AM - "resident in bed, checked resident skin - noted to right and red area

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Brighton Gardens Of Boca Raton	6347 Via De Sonrisa Del Sur Boca Raton, FL 33433	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

to left. Cleanse area with NS applied dressing to both areas. Physician #A called, left message with nurse, husband notified."

q) 8 PM - "Drsg in place and intact to

r) 8 AM - "Called by care manager to resident's dressings from previous day were removed due to soiled (illegible), cleansed areas with NS - open area noted to right and left bony areas, applied cream dry protective dressing, Physician's #A resident's PCP called again, asked for care order, left message with (name) - waiting for reply. Family notified. Cushion on the wheelchair in use, care manager (illegible) instructed to change resident routine Q 1 hour. Resident (illegible) non compliant with repositioning, P 86, R 18, T 98.2, of B&B needs x 2 for toileting and transfer."

s) 8 PM - "Res been observed, sleeping in bed (illegible) in bed. Resp even and unlabored. Clean & changed by care manager + repositioned Q 2 hours. DRSG in place and dry, no complaints noted, will continue to monitor res. Left message Physician #A regarding care order waiting."

t) 12:30 - "Spoke with son (name) concerning PCP, stated that they are in process of getting Medicare for his mother and that by next week they will have a PCP."

u) 14:55 - "Late entry for 5:30 PM - Physician #A contacted regarding woundcare order for to office staff informed that doctor will no longer follow resident or give orders for resident because her thirty day notice is up. When ask when it was giving Rep responded that family was given 30 day notice since Husband was called to wellness regarding this situation but says he does not remember if he received notice or not, per conversation between nurse and husband the family has not found a new pcp for the resident because they're in the middle of changing her medical coverage when ask husband says that the residents (name inserted) coverage was terminated on Nurse suggested taking resident to woundcare center nurse contacted (name) woundcare center to obtain info for the family regarding how much woundcare would cost. Woundcare staff instructed to call back in the morning and speak with Donna regarding payment, ins, and appointment. Staff has been instructed to keep resident in bed pressure off the and turning every hours."

v) 15:18 - "Transferred to (name) hospital; Reason for transfer: Elevated temp (102.4), shivering and Condition of Resident Upon Transfer: awake, alert, and responsive; Vital signs: RR 20. Pulse 89, Temp 102.4; Transportation : AMR; Notifications: Son was made aware by HCC."

The treatments given to the resident by the facility's licensed nursing staff, were not ordered by a

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licensed practitioner. This included the use, application, removal, reapplication, and monitoring of the dressings, as well as the dressings and treatments applied to the of the arm and leg. In addition, there was no evidence found the on the arm or leg were being monitored for healing progress and the appearance of the sites evaluated. There was no evidence her heels were being offloaded and skin prep was being applied to bony prominences, as stated under nursing services required on her 1823 assessment form. There ws no evidence found her son, responsible party, was made aware of her skin concerns on .

An interview was conducted with the Licensed Practical Nurse (LPN) who cared for Resident #1 on at 2:40 PM. She described making an entry in the medical record after viewing the on but decided she was unable to complete the progress note. She stated she was concerned how to describe the area, the area presented "black" in color, and she wanted the Registered Nurse (RN) to view the site. She verbally described the area as "golfball" size. She indicated she did not know how to stage the in the presence of "black" color presentation. She indicated she informed the RN by telephone and by written note. She stated the resident did not have a physician in place to care for her, so she was not able to notify a physician to obtain treatment orders.

An interview was conducted on at 3:12 PM, with the care manager assigned to Resident #1 on and ongoing. She expressed on she observed on the right and left and reported the areas to the nurse. She stated the resident did not have a cushion in her chair and a towel was used on the seat. She stated she observed on the on the right and left were open areas and a nurse applied treatment to each . A cushion was then provided for the resident in her chair. She expressed on the dressings came off and new ones were applied by the nurse. She stated on she spoke to the RN about the areas. She described she took the resident to the memory unit for the day per the resident's normal routine, and was called every 30 minutes to return to the unit to reposition the resident. She stated on she was instructed to keep the resident in bed for the day. She stated she fed her lunch in her the resident did not want to eat, and she noticed a change in the resident. She stated the resident had an elevated temperature, was shivering, and was later sent to the hospital.

Review of the hospital records when the resident was transferred on indicated she was admitted and treated for ischael . This was validated in her hospital discharge summary, dated She underwent a debridement of the on The report, dated documented under Post Diagnosis, Ischeal . Under Procedures Performed, documentation revealed, Debridement of Ischael x 2".

An interview was conducted on at 3:42 PM, with the Executive Director. He expressed he was

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not made aware of the skin issues or lack of physician services for the resident, until after she was discharged to the hospital. He was made aware by the resident's son on . He validated the licensed nursing staff performed LNS treatments on the resident without a physician's order which constituted deficient practice. He stated the RN involved no longer worked at the facility.

Class II

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Brighton Gardens Of Boca Raton
6347 Via De Sonrisa Del Sur
Boca Raton, FL 33433

Dear Administrator:

This letter reports the findings of a Complaint #2014006587 inspection survey conducted on by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0000 - - Initial Comments
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= G
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - N277 - 58a-5.031(2) Fac - Lns - Resident Care Standards S-S= G

Directed Corrective Actions:

1. The Assisted Living Facility is required to establish a policy and procedure for the prevention and/or worsening, identification, development, and treatment of pressure sores and other skin related concerns. The facility must maintain a log of active skin concerns, which includes location and staging. This log should contain information regarding who will be responsible for providing the nursing service (ie. Home Health, ALF nurse, Hospice). The log must include date of development and determination of facility-acquired or non facility-acquired. Note: If the resident is receiving LNS (Limited Nursing Services) services for a the LNS protocol should also be implemented and applied.

2. The Assisted Living Facility shall contract or provide training for all licensed nursing staff on proper identification of a vs. and other skin related conditions. The training must

include the proper staging of sites, with definitions. The training information must incorporate the current industry standards. The training must be conducted by a knowledgable, reputable, outside source.The training should be documented with course content, attendance information and the instructor(s) qualifications.

Educational Resources include:

• The Clinical Practice Guidelines from the Agency for Healthcare Research and Quality (AHRQ) www.ahrq.gov (Guideline No. 15: Treatment of and Guideline No.3: in Adults: Prediction and Prevention)(AHRQ was previously known as the Agency for Health Care Policy and Research [AHCPR]);

• The National Advisory Panel (NPUAP) www.npuap.org

• The American Medical Directors Association (AMDA) www.amda.com (Clinical Practice Guidelines: 1996 and Companion, 1999);

• The Quality Improvement Organizations, Medicare Quality Improvement Community Initiatives site at www.medqic.org;

• The Ostomy, and Continence Nurses Society (WOCN) www.wocn.org

3. The Assisted Living Facility is required to monitor the progress of and other active skin concerns on a daily basis, along with a weekly visualization and assessment completed by the Registered Nurse Health Care Coordinator. The facility must document the daily and weekly results in the resident's medical record and track the progress.

4. The Assisted Living Facility shall complete a thorough review of each current resident's skin status and identify risks for development. The facility shall develop and implement a process to review each new admission for skin status and risk of development as part of the admissions process. All such assessments must be documented in the resident's record.

5. The Assisted Living Facility shall develop and implement a process which ensures that for each resident identified with skin integrity or

a. Interventions to prevent the development or worsening of skin degradation are put in place with physician orders where appropriate.
b. Resident health care providers are regularly informed of the status of each intervention implemented and its efficacy.
c. An identified staff member is designated to review, no less than weekly, skin degradation measures to ensure that interventions are being implemented and that physicians are notified of treatment status. Results of this periodic review shall be reported to the Administrator or the Administrator's designee.
d. These process must be documented and the documentation maintained.

6. The Assisted Living Facility shall complete a thorough review of each current resident to determine that each resident has a designated health care provider. The facility shall develop and implement a process to ensure that each resident has and maintains a designated health care provider and establish standards for facility interactions with resident health care providers to ensure continuity in the provision of care.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call .... Kimberly Smoak, Survey and Certification Support Branch, at (850) 412-4516 or Tikel Wedges-Phoenix, Health Facility Evaluator Supervisor at (561)381-5840.

Sincerely,

T. Wedges-Phoenix, Supervisor

Arlene Mayo - Davis
Field Office Manager

AMD/jw

D7JR