STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912046	12/02/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Livewell At Coral Plaza	5850 Margate Blvd. Margate, FL 33063	
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List of Tags Cited:
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0027 - 58a-5.0182(3) Fac - Resident Care - Arrangement For Health Care S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced licensure complaint survey, CCR#2014008477, was conducted on [redacted] through [redacted] and [redacted] at Livewell at Coral Plaza. The facility had deficiencies found at the time of the visit for the complaint survey.

This survey was conducted in conjunction with the follow-up complaint revisits survey to CCR#2014006164, CCR#2014005964 & CCR#2014005985.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on on record review and interview, the facility failed to ensure residents have a face-to-face medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first to ensure the resident met the criteria for continued residency, for 6 of 6 residents' records reviewed. (Resident #1, #3, #4, #6, #10 & #13)

The findings include:

1) Resident #1 was admitted to hospice care in 2013 while a resident of the facility. Review of the most current Health Assessment (AHCA form 1823) dated [redacted] in the resident's record revealed no evidence of documentation of the resident's change in condition to include admission to Hospice care. Further review of the Health Assessment (AHCA form 1823) , the physician documented under Nursing/Treatment requirements, instructions for treating a left hip [redacted] (stage not documented) and under Section C. Does the individual have any of the following conditions it is documented 'No' under Any [redacted] 3 or 4 pressure sores. Review of the resident's record revealed documentation from the Hospice nurse dated [redacted] stating the resident has a left hip [redacted] not healing since [redacted] 2014.

On [redacted] at approximately 11:00 AM, an interview was conducted with the Director of Nursing who concurred an admission to Hospice care is a change in condition and the Health Assessment (AHCA form 1823) should reflect that change.

2) A review of Resident #3's record revealed an admission date of [redacted] and a Health Assessment

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(AHCA form 1823) dated to include a diagnosis of Parkinson, Ataxia and Heat Failure Special precautions noted as The form documented Resident #3 requires total assistance with all activities of daily living and independent with eating. Page 2 of the form under the comment section documented "advanced Parkinson suggest hospice care". During an interview on at 11:20 AM with the Director of Nursing (DON), Resident # 3's record was reviewed and it was noted the record did not contain evidence of documentation indicating the resident had been exam by a doctor after the admission to hospice on with a diagnosis of functional decline and

3) Review of the record for Resident #4 revealed she was under Hospice care. However, there was no evidence of documentation when she was admitted to hospice. On at 12:18 PM, an interview was conducted with Medication Technician #10 who when asked when Resident #4 was admitted to Hospice replied the resident has been on hospice for years. Review of the latest Health Assessment (AHCA form 1823) dated found in the record does not document the resident is currently on Hospice to reflect the change in her condition.

4) A review of Resident # 6's record revealed an admission date of and a Health Assessment (AHCA form 1823) dated and a diagnosis to include and forgetful. The form documented Resident #6 is independent with all activities of daily (ADLs). Further review of the record revealed the resident started care with hospice on with a diagnosis of During an interview on 11 at 12:30 PM with the DON, Resident #6's record was reviewed and it was noted the record did not contain evidence of documentation the resident had been exam by his/her doctor after their admission to hospice on

5) Review of the record for Resident #10 revealed a Health Assessment (AHCA form 1823) dated The Health Assessment was noted to be incomplete with no documentation under or Behavioral Status and Special Precautions section. Additionally, the question indicating whether the resident requires assistance with medications is blank. On at approximately 11:00 AM, an interview was conducted with the Director of Nursing who stated they are going through all the resident charts and color coding them to reflect when the resident needs an update of the AHCA form 1823 and looking at this resident's chart it looks like it was recently updated. She further stated they have been working very hard to ensure that the documentation is complete and will address all the resident's Health Assessment (AHCA form 1823) going forward to ensure nothing is missing.

6) Review of the record for Resident #13 revealed she was recently admitted to the locked memory care unit within the facility on Further review of the record revealed an incomplete Health Assessment (AHCA form 1823) dated with the resident's Medical History and Diagnosis and whether the resident requires assistance with medications is blank. On at approximately 2:00 PM, an interview was conducted with the Assistant Director of Nursing inquiring about the diagnosis for Resident #13 to which she stated she thinks it's

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0027-Resident Care - Arrangement for Health Care 58A-5.0182(3) FAC
Based on interviews and record reviews, it was determined the facility failed to ensure that it coordinated [redacted] work laboratory orders for a resident as physician order and that the orders were completed in a timely manner, for 1 out 1 sampled residents' laboratory orders reviewed, (Resident #8).

The findings:

Review of Resident #8's record revealed a physician order dated [redacted] for laboratory [redacted] work to include a CMP (complete [redacted] panel), [redacted] Lipid panel and [redacted] D level. Review of the Resident Observation Notes dated [redacted] documents 'Resident seen by doctor. New orders written. Labs to be done. Faxed to lab company.' Further review of the record revealed the results of these [redacted] tests were dated [redacted]

On [redacted] at 2:34 PM, an interview was conducted with Employee #10, a Medication Technician, inquiring about the process of obtaining and relaying lab results to the physician. Employee #10 stated when lab results are faxed from the lab they are faxed to the doctor the same day and the doctor responds with whatever orders they wish to put in place. An inquiry was made to Employee #10, if the [redacted] tests dated [redacted] were sent to the physician and she stated after looking at the pages stated they are supposed to put the 'Fax' stamp on the page when you fax it to the doctor and it looks like this one was not faxed to the physician.

On [redacted] at 2:40 PM, an interview was conducted with the Assistant Director of Nursing (ADON) who was not sure why it took 2 months to do the labs and then stated it was probably because the physician wrote the order on the old order sheets and it got missed. Further review of the record revealed the physician visited the resident on [redacted], the day he wrote the order for the [redacted] work and then again on [redacted] with the [redacted] work now being done on [redacted] The ADON stated the doctor probably noticed the [redacted] work was not in the chart and brought it to someone's attention, that is why it was then completed on [redacted] The ADON was asked about the process for notifying the physician of lab results, and after scanning the [redacted] results making note of the high and low values of some tests, stated it looks like this was not faxed to the physician as yet, as they are to put a 'Fax' stamp on the page with the date and time it was faxed.

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on interview and record review, the facility failed to ensure all Medication Observation Records were accurate and up-to-date as assistance with medication was provided to a resident(s). As evidence of the facility failure to ensure treatments were documented on the MORs as ordered, for 11 of 11 residents being treated for [redacted] or being treated preventively for [redacted] (Resident #4, #5, #6, #11,

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#13, #17, #18, #19, #20, #24 and #25.).

The findings include:

1) During an interview on at 10:35 AM with the facility physician, she stated she diagnosed and confirmed 4 cases of in the locked unit; so all 20 residents were treated as a preventative measure. She stated the residents will be treated with the Eliminite Cream again in one week as part of the treatment.

Review of 11 sampled residents' MORs for the month of 2014 and 2014 revealed the following.

a)) Resident #4 was admitted to the facility on . Review of Resident #4 ' s record revealed a physician order dated for lotion 4 times daily to affected area until resolved. Review of the Resident Observation Notes revealed documentation dated with the next entry being with no evidence of documentation for the indication for the lotion. Review of the Medication Observation Record (MOR) revealed a hand written note for the lotion to be applied to affected areas 4 times a day until resolved with a hand written note where the person(s) applying the lotion 4 times daily would sign off, is written (name of Hospice company). Review of the MOR revealed a pharmacy computer generated order for the Calydryl with times stamped for administration to be 8 AM, 12 PM, 5 PM and 9 PM with a hand written note next to the times is written (name of Hospice company). On at 12:09 PM, an interview was conducted with the Assistant Director of Nursing (ADON) who stated the lotion is being put on by hospice staff. An inquiry was made to the ADON if they apply it 4 times a day and she stated hospice is here all day, then stated between our staff and hospice it gets done. An inquiry was made to the ADON for the indication for the lotion and she stated the resident has a however was unable to state where the might be. On at 12:30 PM, an interview was conducted with the Hospice Registered Nurse who stated when the Hospice aide comes in early in the morning she would put the lotion on after morning care, usually on the back, flank and arms as the resident gets itchy. She stated the lotion would at least be put on once a day by their staff but the other 3 times they would not be applying it.

b) Resident #5 was admitted to the facility on . Review of the record revealed a Physician Telephone Order sheet received by the Director of Nurses (DON) dated to 'Stop Evisa 60 mg for 3 months.' Review of the Medication Observation Record for the month of 2014 revealed the Evisa 60 mg continued to be given up to and including and not discontinued as ordered. On at 11:53 AM, an interview was conducted with the DON who was apprised the medication was not discontinued as ordered in . She had no comment except to inform the Assistant Director of Nursing the medication continued to be given for the month of and was not discontinued.

c) Review of the Resident Observation Notes for Resident #6 revealed documentation dated 11-14, with no specific date documented, 'Resident being treated as a precaution to being exposed to ' Review of the MOR for 2014 revealed a hand written note for Eliminite Cream

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dated [redacted] with no documentation the treatment was rendered.

d) Review of the Resident Observation Notes for Resident #11 revealed documentation dated [redacted] 'Call placed to family to advise the precaution of using Eliminite Cream on his father.' Review of the MOR for [redacted] 2014 revealed a hand written note for Eliminite Cream dated [redacted] with no documentation the treatment was rendered.

e) Resident #13 was admitted to the facility on [redacted] to the locked [redacted] unit. Review of the Medication Observation Record (MOR) revealed on [redacted] the resident was ordered Triomicinolone cream to trunk twice daily until healed. Review of the Resident Observation Notes revealed documentation on [redacted] with the next entry dated [redacted] with no evidence of documentation for the indication for the treatment ordered on [redacted].

On [redacted] at approximately 2:00 PM an interview was conducted with the ADON inquiring about the indication for the cream twice daily and she stated she thinks it is for a [redacted] but was not sure.

f) Review of Resident #17's MOR for [redacted] 2014 revealed a hand written note for Eliminite Cream dated [redacted] with no documentation the treatment was rendered.

g) Review of the Resident Observation Notes for Resident #18 revealed documentation dated [redacted] that the resident was treated for suspected [redacted] and that a call was placed to family to advise the precaution of using Eliminite Cream. Review of Resident #18's MOR for [redacted] 2014 revealed a hand written note for Eliminite Cream dated [redacted] with no documentation the treatment was rendered.

h) Review of the Resident Observation Notes for Resident #19 revealed documentation dated [redacted], that the resident was treated with Eliminite Cream as a precaution within the unit. Review of the MOR for the [redacted] 2014 did not document the physicians order or that the treatment was rendered.

i) Review of the Resident Observation Notes for Resident #20 revealed documentation dated 11 [redacted] that a call was placed to the resident's niece to advise Eliminite Cream as a precautionary measure. Review of the MOR for [redacted] 2014 did not document the physicians order or that the treatment was rendered.

j) Review of the Resident Observation Notes for Resident #24 who was identified by the DON to live in the locked unit did not document the [redacted] Cream treatment or that family was notified. Review of the MOR for [redacted] 2014 did not document the physicians order or that the treatment was rendered.

k) Review of the Resident Observation Notes for Resident #25 who was identified by the DON to live in the locked unit did not document the [redacted] Cream treatment or that family was notified. Review of the MOR for [redacted] 2014 did not document the physicians order or that the treatment was rendered.

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During an interview with the DON on at 4 PM, aforementioned findings were confirmed. The DON stated no further documentation was available for review.

Class III

0079-Staffing Standards - Levels 58A-5.019(3) FAC
Based on record review and interview, the facility failed to provide adequate staffing to meet the care needs of the residents, including supervision. As evidence of the facility failing to provide additional staffing above the minimum staffing standards for a census of 134 in which the care needs could no longer be met at the minimum staffing levels.

The findings include:

1)The facility is licensed for 140 beds. On the facility census was 134, 114 residents on the first and second floors of the facility and 20 residents residing in the locked unit.

Review of residents' records and facility Incident Log entries from 2014 through 2014 revealed documented incidents; which occurred after 6 PM when the staffing ratio drops to 5 staff members on duty from 6 PM to 10 PM and from 10 PM to 6 AM when the staff ratio goes down to 3 staff available for the first and second floors and 1 staff member for 20 residents in the locked unit. The following incidents were noted to have occurred during the hours in which staff had been reduced.

a) Resident #30 was observed 'outback' on the floor on 14 at 12: 10 AM. He was assisted back in his chair and taken to his

b) Resident #31 was found on the floor in a sitting position in the lobby on at 8:30 PM. He sustained a to his left elbow.

c) Resident #16 was observed on the floor on at 12:30 AM. He was heard calling for help. His call light was broken and his wheelchair was not locking. He when trying to go to the Resident #16 was observed on the floor on at 2:10 AM. He trying to get into bed.

d) Resident #32 was observed on the floor in his at 10:45 PM. He was attempting to go to bed.

e) Resident #33 was observed on the floor in the hallway on at 12:15 AM. He tripped attempting to get to his

f) Resident #32 was observed on the floor in her at 3:40 AM. She on her way to the

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g) Resident #12 was observed on the floor in the shower in his [redacted]. He [redacted] trying to use the [redacted].

h) Resident #35 was found on the [redacted] on [redacted] at 8 PM. She was on her way from the [redacted].

i) Resident #36 was found on the [redacted] on [redacted] at 9:30 PM. 911 was called but the resident refused to go to the hospital.

j) Resident #35 was found on the floor in her [redacted] at 5 AM. The family was notified the resident's slippers are slippery and have no grip. Resident #35 was observed on the floor in her [redacted] at 6:15 AM at change of shift.

k) Resident #6 was observed on the floor in the hallway of her [redacted] at 12:15 AM, 911 was called but the resident refused to go to the hospital. On [redacted] at 2:30 AM resident observed on the floor in [redacted]. On [redacted] at 5:35 AM resident observed on the floor, resident refused to go to the hospital. On [redacted] at 5:06 AM resident observed on floor hit head; laceration to scalp and [redacted] neck.

l) Resident #37 was observed on the floor in her [redacted] at 12:00 AM.

m) Resident #15 was observed on the floor in her [redacted] at 9 PM. Resident #15's Resident Observation Note dated [redacted] at 10:35 PM, document the resident found on floor [redacted] from her head; 911 called and resident sent to hospital for evaluation. Further review of the Resident Observation Notes dated [redacted] at 3:PM documents Resident #15 was readmitted to the facility. Further review of the resident's record revealed no documentation of the status of the head [redacted] sustained during the [redacted] on readmission or thereafter.

On [redacted] at 11:15 AM, an interview was conducted with the ADON inquiring about the status of Resident #15's head [redacted] to which she replied the resident had a laceration to her head and returned to the facility with [redacted] to her forehead. After review of the resident's clinical record, the ADON concurred there was no assessment or status of the head [redacted] on readmission to the facility or thereafter.

n) Resident #38 was observed on the floor in her [redacted] at 10:30 PM.

o) Resident #12 was observed on last rounds on the floor in his [redacted] at 6:00 AM.

p) Resident #3 was observed on the floor in his [redacted] at 1:00 AM. 911 was called to put him back to bed. On [redacted] resident found on the floor at 7 AM , 911 called to pick him up and him in bed. Further review of the record documented on [redacted] 6 AM found on floor in lying position next to bed. 911 called. [redacted] found on floor in [redacted] trying to go to his wheelchair around 10:40 PM.

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8:30 AM found on floor. 911 called sent to hospital. 1:00 AM resident observed on the floor 911 called. Will notify family in AM. No evidence of documentation the family was notified. On at 7 AM found on floor in . 911 called to pick him up and put him in bed. On at 9 AM sent to hospital due to change in level of

q) Resident #14 was observed on the floor in her at 3:15 AM. She sustained a to the right and was transported to the hospital.

r) Resident #35 was observed on the floor in her at 6:00 AM. She was attempting to get to the

s) Resident #15 was found on the floor in her at 10:00 PM. She was from her head. 911 was called and she was transported to the hospital. Resident #15 was found on the floor in her at 5:50 AM after returning from the hospital.

t) Resident #29 was found on the floor in his at 12:00 AM. He sustained a cut over his right eye.

u) Resident #14 was observed on the floor in her at 8:45 PM. She stated she hit her head. 911 was called and she was transported to the hospital.

On at approximately 11:00 AM, an interview was conducted with the Director of Nursing (DON), who stated after 6 PM there are usually 5 staff members in the facility and on the 10 PM to 6 AM shift there are 4. The DON confirmed the facilities current census was 134. She further stated since she has been here since 2014 there has always been 4 staff on the night shift, 3 for the 2 floors for 114 residents and 1 in the locked unit for 20 residents. She stated she reviewed the incident reports and did not feel that 26 was unreasonable over a 3 month period.

2) A review of the facility 2014 staffing schedule on with the Director of Nursing (DON) revealed 5 employees work the 2 PM-10 PM shift and 4 staff members work the 10 PM-6 AM shift for a current census of 134. Twenty of the residents live in a secured unit. The DON confirmed only 1 employee is assigned to the secured unit on the afternoon (2 PM -10 PM) and evening shifts (10 PM - 6 AM) leaving 4 employees on the 2 PM-10pm shift and 3 employees on the 10PM - 6 AM to supervise and provide care and services to 114 residents. During an interview on at 2:00 PM with the DON and ADON (Assistant Director of Nursing), it was stated by the DON "The facility does not have enough staff to take care of all of these people. It was brought to the attention of the owner who said he would take care of it". According to the DON , currently the issue has not been addressed.

During a telephone interview on at 1:40 PM with Employee #1, a CNA from the 2 PM-10 PM shift, she stated "we have to make it work with only 4 people. It gets busy right after they finish eating and call bells start going off. We can use more help". During a telephone interview on at 1:45 PM with Employee #2, the CNA from the 10 PM-6 AM shift, she stated "more people would be a lot of

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help, sometimes the residents have to wait. We can't get to everyone at the same time".

During an interview on [redacted] at 2:20 PM with Employee #3 who works the 2 PM-10 PM shift, it was revealed "It is a lot to do. We have heavy residents and it takes 2 of us to move them. Sometimes they have to wait a long time for us. We have to run up and down between both floors". During an interview on [redacted] at 2:10 PM with Employee #4 who works the 2 PM-10 PM shift , it was stated "we work together and do the best we can. We could use more help some of the people need a lot of help. We have to go up and down the stairs to help residents". During an interview on [redacted] at 2:40 PM with Employee #5 who works the 2 PM-10 PM shift on the secured unit, it was stated "we could use more help. Sometimes they need extra help in their [redacted] we can't be in 2 places".

During an interview on 11[redacted] at 2:30 PM with a resident who did not want to be identified, stated "Sometimes at night we wait 5-10 minutes. I try not to call too often". During a confidential interview (#2) at 2:45 PM with a resident, it was stated "I wait a long time when I use the call light at night. It can happen any day" During a confidential interview (#3) on [redacted] at 2:50 PM, the resident stated, "I do wait a long time during the morning hours". During a confidential interview (#4) on [redacted] at 2:55 PM, the resident stated "I wait sometimes 15 minutes on the toilet. They need more staff they all congregate in 1 spot and ignore the bells". During a confidential interview (#5) on [redacted] at 2:58 PM, the resident stated "At night we wait a long time but when they come they tell us they are busy with other people".

3) A review of the resident council minutes from [redacted] 2014 also identified staffing and resident call lights complaints. [redacted] No one responding to call lights at night and during the day. [redacted] nursing comments "There may be a wait time of 15 minutes when pulling the emergency light cord". Why are CNA's not helping residents into the dining [redacted]. Reason: "It is a scheduling problem." "Can we be weighed in a more private place. Reason: We used the dining [redacted] everyone was easy to get". [redacted] 2 residents complained they wait too long to be helped by the CNA's "More help needed."

During the survey the facility was not able to provide evidence of documentation they addressed any of the residents complaints from the resident council meetings regarding staffing, call light response time or [redacted] in the morning meetings.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observation and interview, the facility failed to ensure the residents' nutritional needs are met by offering a variety of meals adapted to the food preferences, including snacks as necessary, to accommodate resident needs and preferences. As evidence of the facility running out of the main dish; not following the menu or having the listed alternate available; and not serving food at palatable temperatures.

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The findings include:

1) A review of the facility weight book on at 10:30 AM documented the following residents had a weight loss greater than 10 from 2014 to 2014:
a) Resident #4 weights: 108 97 lbs. Observation of the resident on at 1:10 PM notes the resident looks thin for his body build and height and is not interviewable.
b) Resident #21 weights: 150 138 lbs. Observation of the resident on at 1:05 PM notes the resident is with the aide and his bony shoulders could be observed poking through his shirt. The aide stated he is eating better now.
c) Resident #22 weights: 114 102 lbs.
d) Resident #23 weights: 201 187 lbs.
e) Resident #24 weights 201 189 lbs.
f)Resident #25 weights: 154 136 lbs.
g) Resident #26 weight 104 95 lbs.
h) Resident #27 weights: 202 147 lbs.
i) Resident #28 weights: 268 238 lbs.

During an interview on at 11:10 AM with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) regarding resident's weight loss, the DON stated "Residents are weighed by the ADON, kitchen personnel and certified nurse assistants (CNA). There is no consistent person doing the weights". The DON does not know who entered the weights and had no way to go back and find out. She stated we don' t address weight loss in the morning meeting. The policy for weights and weight loss was requested.

2) Observation on at 11:40 AM of the meal times posted outside dining the following: breakfast 7:30-9:30, lunch 11:30-1 PM, dinner 4:30-6 PM.

a) During interviews in the dining the lunch meal with residents who did not want to be identified on the following was revealed: At 11:48 AM, one resident stated "food is not good or appetizing. They run out of the main dish so we have to get a sandwich, it happens a lot". A second resident at the table stated "sometimes they run out of the main dish. The fruits served are not ripe. If you complain or they have no fruit they give us canned fruit. It happens during lunch and dinner but most of the time its dinner". Both residents stated they do not get any night snacks " if you hungry you're on your own".

b) During interviews conducted on at 11:55 AM at a second table, the residents revealed the following. The residents stated "occasionally they run out of food for lunch and dinner. Soup is We eat a lot of macaroni". They confirmed the facility did not offer snacks after dinner.

c) During interviews conducted on at 12:00 PM at a third table, the residents revealed the following. The residents stated, "No I don ' t think they have snacks at night. If you're hungry you're on

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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

your own".

d) During interviews conducted on [redacted] at 12:05 PM at a fourth table, the residents revealed the following. One resident was observed eating the fruit plate containing canned fruit and a scoop of cottage cheese. It was also stated that sometimes they run out of the main dish and yesterday it was the chicken parmesan . Residents also stated they do not have any [redacted] deserts.

e) During interviews conducted on [redacted] at 12:12 PM at a fifth table, the residents revealed the following. Residents stated, "They do not get any [redacted] snacks, sometimes they run out of the main dish for lunch and dinner". The residents stated they serve a lot of rice and pasta. They do not have snacks at night, they are on their own. They complained they are finished with dinner around 5:15 PM, that's it for meals. If we came here at 6 PM they would have nothing and it is a long time until breakfast.

f) During interviews conducted on [redacted] at 12:25 PM at a sixth table, the residents revealed the following. Residents stated "the food is terrible, coffee and soup are served [redacted] They run out of food sometimes, yesterday it was the chicken parmesan. They serve too much pasta and rice and have no [redacted] snacks. If they come at 6 PM for dinner they are out of food. Sometimes they get small portions and the meals are served too close together. They do not have snacks at night".

g) During interviews conducted on [redacted] at 12:29 PM at a seventh table, the residents revealed the following. The resident's stated "If you want more food they won't give it to you. Extra ice cream they say no. We can't get an extra scoop of tuna fish and it bothers me people my age can't get enough food. They run out of food, it does not taste good and sometimes we get chicken for lunch & dinner." The residents stated once they complained about the quantity of food at a resident council meeting and in front of everyone the Administrator told them to go to a restaurant. They no longer attend the resident council meetings".

3) Observation in the kitchen on [redacted] at 12:45 PM with the food server, it was noted the kitchen was already cleaned. The surveyor was looking for the day cook and was told they already left. During an interview at 12:50 PM on [redacted] with a kitchen employee it was stated "Sometimes we run out of the main dish but not all of the time. We do have snacks, not sure what time they are served".

During an interview on [redacted] at 9:40 AM with the day cook, it was stated yesterday they did not have the turkey sandwich listed on the menu because her boss did not order it. It was confirmed on occasion they do run out of the main dish and will offer an alternative. They stated their boss is the person in charge of ordering food and he is on vacation. It was also stated that they do serve a lot of chicken, pasta and rice. During an interview at 12:20 PM on [redacted] with the night cook , it was

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	AL11912046	12/02/2014
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stated "Yes we run out of the main dish at night sometimes. We have to offer them PB & J or fruit".

4) On [redacted] at 10:55 AM, a resident was observed to come to the first floor nursing/medication [redacted] state "I'm hungry, may I have a sandwich" to which medication technician Staff Member #10 replied "We don't have sandwiches, that is only for nights. All we have are crackers." The resident replied, "I don't want crackers, I want a sandwich." Staff Member #10 reiterated "we don't have sandwiches, I'll get you a cracker " Staff Member #10 was then observed to go to the wall shelving unit and attempt to retrieve a large sealed plastic barrel looking container which was a quarter full of graham crackers. Staff Member #10 after several attempts, was unable to reach the container stating "I'm too short." A [redacted] observed next to the shelving unit and a suggestion was made to Staff Member #10 to use the [redacted] to push the container to the edge of the shelf to which she proceeded to use the [redacted] to push the container to the edge of the shelf and tip it over to be able to reach it. She was then observed to take out a graham cracker package and give it to the resident to which the resident replied "I don't want a cracker" to which Staff Member #10 replied "that's all we have, you'll have to wait for lunch then."

5) Although the posted meal times identify 13.5 hours from dinner service to breakfast service the resident consensus confirmed by the staff reveal the kitchen occasionally runs out of the main dish at dinner often and residents are usually finished with dinner by 5:15 PM. If they were to come to the dining [redacted] 5:15 PM, the kitchen could be out of the main dish. The residents also stated the meals are served too close together leaving a long time after dinner and between breakfast without any snacks.

A review of the resident council meeting minutes from [redacted] 2014 through [redacted] 2014 document the following food complaints: [redacted] 2014 residents complain juice is diluted too much "AN'S. Reason: The juice is preset by the state and currently cannot be changed" Fruit is not ripe. [redacted] 2010 complaints food is not hot and more fruit is requested. [redacted] no food or cookies for [redacted] "Omelets will no longer be made. Reason: They have become too popular staff no longer has time to make them". Complaints: Corned beef was hard and rubbery "Reason poor quality meat". Cabbage was old, would like more vegetables. "Reason amounts are according to state guidelines" , "Can we be weighed in a more private place. Reason we use the dining [redacted] everyone was easy to get". [redacted] soup served [redacted] There is no evidence of documentation the facility addressed any of the residents food complaints

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On [redacted] at 2:30 PM the facility Weight Policy was reviewed and documents "It is the the policy of Livewell at Coral Plaza to obtain, document and review each resident's weights every 6 months for the purpose of identifying trends and/or changes in a resident's weight over a period of time and ensuring appropriate interventions are implemented to maintain residents nutritional status...Weight loss will be reported to the attending physician".

During an interview on [redacted] at 1:15 PM with the Administrator, regional employee and ADON, they were informed of and acknowledged the findings. During the survey the facility was not able to provide evidence of documentation they addressed any of the residents complaints from the resident council meetings regarding food for the past 6 months, found a private place to weigh residents, weight loss, notified the residents physicians regarding weight loss or implemented interventions to maintain the residents nutritional status.

Class III

0162-Records - Resident 58A-5.024(3) FAC

Based on observation, interview and record review, the facility failed to ensure resident records were complete to include documentation of resident weights, for 1 of 10 residents' records reviewed for weight loss (Resident #9).

The findings include:

Review of the clinical record for Resident #9 revealed he was admitted to the facility on [redacted] with diagnoses to include [redacted] and [redacted]. Review of the facility's Admission Sheet reveals no documentation of a height or a baseline admission weight. Review of the facility's Weight Chart in the resident's record for the year 2014 is blank. Review of the Health Assessment (AHCA form 1823) reveals no documentation of the resident's weight.

Further review of Resident#9's record reveals documentation dated [redacted] at 10 AM, the 'Resident ate 100% of breakfast.' It was noted the record revealed the only other reference to diet and meal consumption is documentation on [redacted] at 10:00 AM, stating 'Resident complains of not feeling well, seems [redacted]. Patient noted to consume 20% of meals. Discuss with (family member) possible supplement as patient is very thin.'

On [redacted] at 10:45 AM, an interview was attempted with Resident #9. The resident was observed to be thin looking for his body build. An inquiry was made to the resident about his appetite and meal consumption. However, he responded with [redacted] answers and was unable to answer the question.

On [redacted] at approximately 3:00 PM, an interview was conducted with the Assistant Director of Nursing who could not speak to why an initial or subsequent weights were not done for Resident #9.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Livewell At Coral Plaza
5850 Margate Blvd.
Margate, FL 33063

RE: CCR #2014008477

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on 19-21, 2014 and 2014 by representatives of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after to verify that 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 the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Davis
Field Office Manager

AMD
Enclosure

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