STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943030	12/31/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Treemont On The Park	3881 NE 3rd Avenue Oakland Park, FL 33334	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0000 - - Initial Comments
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance with Self-Admin S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C

Specific Tag Findings:

0000-Initial Comments

An unannounced Relicensure survey was conducted on ..... and ..... at Treemont on the Park. The facility had deficiencies found at the time of the visit.

Note: Relicensure survey was conducted in conjunction with a complaint survey, CCR #2014010727, please see separate report for findings.

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

Based on observation, interview and record review, the facility failed to ensure that a resident's Health Assessment Form (AHCA form 1823) was accurate and reflective of a resident's current care needs and services, for 1 out of 2 sampled residents (Resident # 3).

The findings include:

On ..... a record review of Resident # 3's AHCA form 1823 form revealed an admission date of ..... and his last medical exam dated for ..... with the following diagnosis: ..... type, ... and ..... Further review of Resident # 3's file found that as of ..... Resident # 3 has a ..... right heel ..... that he developed while being admitted into the hospital.

In an interview with the ..... Care Registered Nurse (RN) from the Home Health Agency on ..... at 11 AM, he stated Resident # 3 has a ..... of the right heel since the first

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week of ... that has shown improvement. He stated currently, Resident # 3's right heel ... is still at ... and they are providing ... care for Resident # 3 three times a week. The ... Care Nurse stated he updates notes and assessments in Residents # 3's home health agency file and communicates with the staff in the assisted living facility.

During an interview on ... with the Administrator, he stated when Resident # 3 came back from the hospital on ... he notified Resident # 3's physician about his right heel ... and the physician prescribed ... care. Record review found Resident # 3 is receiving ... care from a registered nurse from a Home Health Agency 3 times a week. The record review of Resident # 3's file found no new AHCA form 1823 form since his admission date documenting a significant change in health status which indicates right heel ...

On ... at 1:30 PM, the Administrator acknowledged the findings and stated no further documents were available for review.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on observation, record review and interview, the assisted living facility failed to limit the use of physical ... to half-bed rails and failed to obtain the consent of the Resident and/or the Residents' representative prior to the use of bed rails for 1 out of 2 sampled residents' records reviewed (Resident #10).

The findings include:

During an observation made on ... at 10:00 AM, it was noted that Resident #10 was lying in bed with full side rails in the up position.

Record review found Resident #10 was admitted on ... Record review found a bed rail order dated ... for a full bed rail for safety. Resident 10's record lacked consent for bed rail use from the Residents' representative or the resident prior to the use of bed rails.

In an interview conducted on ... at 2:45 PM with the Administrator, he acknowledged that he is aware that only 1/2 bed rails are allowed to be utilized in assisted living facilities. He also reviewed the

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record and confirmed that the record lacked the consent for use of the bed rails.

During an observation made on [redacted] at 8:15 AM, it was noted that Resident #10 was lying in bed with full side rails in the up position. During an interview with Staff C on [redacted] at approximately 8:30 AM, she stated that Resident #10 is incapable of lifting the rails up or down. During an interview with Staff D on [redacted] at approximately 8:35 AM, she stated that Resident #10 is incapable of lifting the rails up or down. In an interview with hospice aide on [redacted] at approximately 8:40 AM, she confirmed that Resident #10 is incapable of lifting the rails up or down. In an interview with the Hospice nurse on [redacted] at approximately 9:15 AM, he stated that Resident #10 is incapable of lifting the rails up or down and that the bed rails were ordered for safety.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation and interview, the facility failed to follow the proper procedures for providing assistance with self -administration of medication, for 3 out of 3 residents (Resident # 10, # 11, and # 13) observed during medication pass.

The findings include:

a) Observations on [redacted] at 11:45 AM, found Resident # 11 receiving the following medication: [redacted] HCl 50 mg, one tablet. At 11:45 AM, observations during assistance with self- administration of medication revealed Staff A, unlicensed staff member, assisted Resident # 11 with self - administration of medications. Staff A did not sanitize her hands, took the medication out of a locked medication cart, walked away from the medication cart and left it unlocked and unsecured, put the medication in Resident # 11's hands and announced the name of the medication , did not watch her swallow the medication, and signed the medication observation record.

b) Observations on [redacted] at 11:48 AM, found Resident # 10 receiving the following medication: [redacted] 0.5 mg, one tablet. At 11:48 AM, observations during assistance with self- administration of medication revealed Staff A, unlicensed staff member, assisted Resident # 11 with self - administration of medications. Staff A did not sanitize her hands, took the medication out of a locked medication cart, walked away from the medication cart and left it unlocked and unsecured, put the medication in Resident # 10's hands and announced the name of the medication , did not watch her swallow the medication, and signed the medication observation record.

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c) Observations on at 11:53 AM, found Resident # 13 receiving the following medication: 30 mg, one tablet. At 11:53 AM, observations during assistance with self- administration of medication revealed Staff A, unlicensed staff member, assisted Resident # 13 with self - administration of medications. Staff A did not sanitize her hands, took the medication out of a locked medication cart, walked away from the medication cart and left it unlocked and unsecured, put the medication in Resident # 13's hands and announced the name of the medication. The medication out of Resident # 13's hands onto the floor. Staff A stated she will have to get another pill for Resident # 13. Staff A did not dispose the medication that on the floor, walked away from Resident # 13 and signed the medication observation record indicating that Resident # 13 took his medication.

During an interview on at 1 PM, Staff A was informed of the process for assisting residents with self- administration of medications. Staff A acknowledged her errors found during the medication observation.

An interview was conducted with the Administrator on at 1:30 PM and he acknowledged the findings.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC

Based on record review, observation, and interview, it was determined that the facility failed to substitute items of comparable nutritional value to the items on the approved cycle menu and also failed to document the substitutions before or when the meal was served for regular and therapeutic diets ..

The findings include:

A review of the dietician approved cycle menu for the lunch meal of revealed the following: 3 oz. Salisbury Steak w/ gravy, 1/2 c mashed potato, 1 slice bread /margarine, 1/2 cup California vegetable, 1/2 c Tossed salad/dressing 1/2 c applesauce 8 oz. beverage.

An observation of the lunch meal on at 11:45 AM revealed the following meal was served: Chili, rice, corn, dinner roll, yogurt and a beverage, a tossed scald or a suitable substitute was not served and yogurt, a dairy product was served as a substitute for the applesauce, a fruit.

In an interview conducted on at 1:25 PM with the Food Service Designee, he confirmed that he did not follow the approved cycle menu, he did not serve a salad or a substitution for a salad, and he did

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not serve a comparable substitute for the applesauce as he served the yogurt as a substitute and it is a dairy not a fruit. He acknowledged that he also failed to document the substitutions on the menu before or during the meal.

In an interview conducted on at 12:35 PM with the Administrator, he confirmed the findings.

Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06
Based on interview, record review and observation, the facility failed to ensure that 1 out of 3 staff members (Staff B) had a Level 2 background screening whose responsibilities may require him or her to, provide personal care or services directly to residents.

The findings include:

On , a record review of Staff B revealed a hire date of as a certified nurse assistant. Further review of Staff B's personnel file lacked documentation of a Level II background screening result.

On at 1:30 PM, the state surveyor called the Agency for Health Care Administration (AHCA) Background screening unit for verification of Staff B's Level II background screening results. The AHCA Background Screening Unit verified that a level II background screening was never completed for Staff B. Further online verification through AHCA Background Screening website revealed Staff B's needs a new screening.

In an interview with the Administrator on at approximately 1:45 PM, the Administrator confirmed that there was no background screening results available in Staff B's file and he was unaware that Staff B did not complete a level II background screening. At 2 PM, the Administrator acknowledged the error of not having Staff B complete an AHCA Level II background screening.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Treemont On The Park
3881 NE 3rd Avenue
Oakland Park, FL 33334

RE: Relicensure Survey

Dear Administrator:

This letter reports the findings of a Relicensure survey that was conducted on 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 representatives. 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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