STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911449	02/12/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
The Plaza At Pembroke Park, Llc	3535 Sw 52nd Avenue Pembroke Park, FL 33023	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - E206 - 58a-5.030(7) Fac - Ecc - Service Plans S-S= D
St - A - E207 - 58a-5.030(8) Fac - Ecc - Services S-S= G
St - A - E208 - 58a-5.030(9) Fac - Ecc - Records S-S= D

Specific Tag Findings:

0000-Initial Comments
There were deficiencies identified during the Limited Nursing Services (LNS) and Extended Congregate Care (ECC) monitoring visit completed on . at the Plaza at Pembroke Park Assisted Living Facility.

(NOTE: This survey was conducted in conjunction with the followup survey to the complaint survey completed on . Please refer to the separate reports.)

E206-ECC - Service Plans 58A-5.030(7) FAC

Based on observation,interview,and record review, the facility failed to follow the requirements for Extended Congregated Care (ECC) licensure. As evidenced by the facility failure to maintain an updated service plan for resident care for 2 of 2 sampled residents receiving ECC (Resident #1 and #2).

The findings include:

1. Review of Resident #1's health assessment dated on . indicated the medical diagnoses of . and a history of . The resident had a . Endoscopic (tube and required bolus feedings via the . for her nutrition and medication administration. She is noted to be alert to name only, "almost bedridden and required assistance with all activities of daily living (ADL). The assessment indicated that the resident had a private care giver 24 hours a day and required continuous O2 for . and chronic .

Review of the facility ECC log indicated that Resident #1 was admitted on . receiving ECC services for care services for . tube.

Review of the service plan from the Resident #1"s admission on . until . indicated no documentation for observation, assessment and monitoring of the . tube or . insertion site. The plan did not indicate the responsibilities of the facility staff and does not accurately indicate the residents current ADL status.

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2. Review of Resident #2's medical history indicated the resident has a medical history including memory loss, and a history of and The resident is alert and oriented and requires partial assistance with ADL care. She is unable to complete her own care and placed on ECC services for care. Review of the facility ECC log indicated that Resident #2, a long term resident was receiving ECC services for care services for the

Review of Resident #2's service plan dated indicated no documentation of the observation, assessment, monitoring or care of the or site. The plan did not indicate the responsibilities of the facility staff.

In a phone interview with the ECC nurse supervisor on at 1:00 PM, she stated that she was responsible for updating the service plans for Residents #1 and #2 and she had not documented the specific care requirements for the residents on the service plan. She stated that she assessed the residents monthly and would update the service plans to accurately reflect the resident care needs.

Class III

E207-ECC - Services 58A-5.030(8) FAC

Based on observation, interview and record review, the facility nursing staff failed to follow acceptable nursing practices under the Extended Congregated Care (ECC) license. As evidenced by the licensed nurse delegating to an unlicensed personnel , the task of administering prescribed nutritional supplements via a Endoscopic (tube to 1 of 1 sampled residents (Resident #1).

This task is a nursing skill that requires specific knowledge of the human body for proper positioning of the resident and establishment of tube placement to ensure the tube has not dislodged or clogged. Residual of stomach content must be checked to determine if feeding was digested. Administering a feeding without this procedure performed first will result in coughing and choking, leading to into the lungs, which results in and perhaps With regard to nutritional supplements,which has the consistency of thickened milk, patency must be determined prior to and after administering the product. This is done by flushing with a specific amount of water, usually 30 cc's. The flush after the supplement is to allow the liquid to flow into the stomach, to prevent the nutritional supplement from sitting in the tube. This is a nursing skill that can become a potentially dangerous situation and direct threat to the resident if performed by one who lacks knowledge and is not trained properly.

The findings include:

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Review of Resident #1's health assessment dated on [redacted] indicated the medical diagnoses of Parkinson's [redacted] and a history of [redacted]. The resident had a [redacted] tube and required bolus feedings via the [redacted] for her nutrition and medication administration. She is noted to be alert to name only, "almost bedridden" and required assistance with all activities of daily living (ADL). The assessment indicated that the resident had a private care giver 24 hours a day and required continuous O2 [redacted] for [redacted] and chronic [redacted].

Review of a physician order dated on [redacted] indicated that the resident was to receive daily bolus feeding thru the [redacted] of 5 cans of Jevity 1.2 nutritional supplement.
Review of the resident's [redacted] 2015 Medication Observation Record (MOR) indicated no documentation that the Jevity supplement was being administered as prescribed by the physician.

In an observation on [redacted] at 10:00 AM resident #1 was lying in her bed with her head elevated, O2 was being administered via a nasal cannula, and a private caregiver was attending to the resident's needs. In an interview with the care giver on [redacted] at 10:05 AM she stated that the resident had been admitted to the facility after several hospitalizations and could not take any food or fluids by mouth. She stated a tube was utilized for administration of medication and nutritional supplement, the resident received 5-6 cans of Jevity 1.2 supplement, 1 can every 3 hours, at 6 AM, 9 AM,12 PM, 3 PM,6 PM and 9 PM, along with water flushes. She was unable to express the amount of water she used to flush the [redacted] tube. The care giver stated that she administered the nutritional supplements for the resident via the [redacted] and the facility nurse administered the medications. She described the procedure she followed for administering the supplement using the [redacted] tube, and stated that she did not check the placement of the tube prior to feeding the resident. The care giver stated that she administers the feeding at the request of the resident's family, adding that she was not a licensed health care provider.

In an interview with the facility nurse on [redacted] at 10:15 AM she stated that the resident is to take nothing by mouth due to a history of [redacted] and [redacted] complications and the resident received all nutritional and medications via a [redacted] tube. The nurse stated that she administered the prescribed medications to the resident but she did not provide the nutritional supplement. She stated that the resident's private care aide administered the supplement via the [redacted] tube at the request of the family. The nurse stated that she followed the appropriate standard of nursing care when she administered the medications but was unsure of the technique used by the aide.

In an interview with the Administrator on [redacted] at 12:00 PM she stated that she was aware that resident #1 required all medications and nutritional supplements to be administered via the [redacted] tube. She stated that the facility had an ECC license and provided the necessary nursing services required for the residents care. The Administrator was informed of the interview conducted by the surveyor, with the facility nurse and private duty aide. She stated that she was unaware that the unlicensed private duty aide was administering the resident's nutritional supplements. The [redacted] 2015 MOR and medical record was reviewed with the Administrator, and she agreed that no documentation of the administration of prescribed nutritional supplement to the resident was available for review. The Administrator stated that she would immediately speak with the resident's family and

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instruct the facility nursing staff to perform all nursing services for the resident.

Class II

E208-ECC - Records 58A-5.030(9) FAC

Based on observation,interview and record review, the facility failed to follow the requirements for Extended Congregated Care (ECC) licensure. As evidenced by the failure to maintain the required nursing progress notes for resident care for 2 of 2 sampled residents receiving ECC (Resident #1 and #2).

The findings include:

1) Review of Resident #1's health assessment dated on indicated the medical diagnoses of and a history of . The resident had a Endoscopic (tube and required bolus feedings via the for her nutrition and medication administration. She is noted to be alert to name only, "almost bedridden and required assistance with all activities of daily living (ADL). The assessment indicated that the resident had a private care giver 24 hours a day and required continuous O2 for and chronic .

Review of the facility's ECC log indicated that Resident #1 was admitted on receiving ECC services for care services for tube. Review of the progress notes from the Resident #1"s admission on until indicated no consistent documentation of the observation, assessment and monitoring of the tube or insertion site.

2) Review of Resident #2's medical history indicated the resident has a medical history including memory loss, and a history of and . The resident is alert and oriented and requires partial assistance with ADL care. She is unable to complete her own care and placed on ECC services for care. Review of the facility's ECC log indicated that Resident #2, a long term resident was receiving ECC services for care services for the
Review of Resident #2's progress notes indicated no consistent documentation of the observation, assessment, monitoring or care of the or site.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2015

Attention: Helen Altieri, Administrator
The Plaza At Pembroke Park, LLC
3535 SW 52nd Avenue
Pembroke Park, FL 33023

Dear ..... Altieri:

This letter reports the findings of a monitoring visit for Limited Nursing Services and Extended Congregate Care conducted on by representatives of the Agency for Health Care Administration. You are directed to comply with the tangible steps outlined below in order to correct the deficient practices. Attached are the deficiencies noted in the investigation.

The investigation resulted in findings of non-compliance with the following area:

E207 ECC Services – Class II - The facility nursing staff failed to follow acceptable nursing practices under the Extended Congregated Care (ECC) license, as evidenced by the licensed nurse delegating to an unlicensed staff, the task of administering prescribed nutritional supplements via a Endoscopic (tube to 1 of 1 sampled residents, (resident #1). This failure posed a direct threat to the health and safety of the resident.

Your facility must comply with the following:

1) All facility staff providing administration of and the assistance with self-administration of medication to residents must be re-trained on correct medication practices by a licensed pharmacist or registered nurse using the 2012 Assistance with Self-Administration Medication Guide released by the Department of Elder Affairs and available on their website at:

http://elderaffairs.state.fl.us/doea/publications.php.
This shall be completed by

Until all staff has been re-trained, the facility's Director of Nursing, administrator or designee who must be a licensed nurse must either administer the residents' medications or be present and directly observe the licensed staff when they are administering the residents' nutritional supplements of medications. The staff must be observed and records monitored for proper

documentation of [redacted] nutritional administration. The facility must implement and maintain a written schedule indicating who is performing this task and documentation must reflect what licensed staff performed the task.

2) Your facility must develop written policy outlining your facility practices for monitoring licensed staff to determine that they are correctly documenting administration of and assistance with self-administration of resident medications and supplements. This policy must also outline your facility's practices for licensed staff administering medications/ supplements via the [redacted] tube and written documentation of the monitoring of these practices. This must be completed by [redacted]

3) Your facility is directed to document in the resident's medical record all monitoring and care provided for the [redacted] tube. The notes must include, at a minimum, who is monitoring the placement and function of the [redacted] tube and must indicate documentation of all daily care and monitoring along with amount of nutritional supplement provided with each feeding. Please be advised that no unlicensed staff shall be involved in monitoring and/or assessment of [redacted] function and care or administration of medications and nutritional supplements via the tube.
This must be completed by [redacted]

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 contact Laura Manville, Assisted Living Enforcement Team Manager at 727-552-1955 or Tikel Wedges- Phoenix, Assisted Living Supervisor at 561-381-5840

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: State form 5000-3547
XG90