| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11911449** | **06/25/2015** |
| 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 TAGS AND REGULATORY IDENTIFYING INFORMATION)

**0000 - Initial Comments**

An unannounced Relicensure survey, with Extended Congregate Care (ECC) and Limited Nursing Services (LNS), was conducted on [redacted] through [redacted] at The Plaza at Pembroke Pines Assisted Living. The facility had deficiencies found at the time of the visit.

**0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC**

Based on observation, record reviews, and interviews, the facility failed to ensure current Health Assessments (AHCA form 1823) were accurately completed for 2 out of 4 residents reviewed (Residents #21).

The Findings Include:

A review of Resident #21' current Health Assessment form (AHCA form 1823) dated [redacted] revealed diagnoses of Chronic Kidney [redacted] III, [redacted] (A-Fib), [redacted] II (DMII), [redacted] incontinence, and [redacted] Resident #21's admission date is [redacted]

Resident #21's [redacted] services on the AHCA 1823 form are documented as Extended Congregate Care. The AHCA form 1823 further documents that the resident is on [redacted] 2 liters via nasal cannula continuously. Record review of Hospice Residents that the Resident Care Director (RCD) provided included Resident #21. Further record review revealed an Integrated Plan of Care for Hospice Services dated [redacted] In an interview conducted on [redacted] at 11:51 AM, Resident #21's family member stated she receives Hospice Services. The current AHCA form 1823 did not note Hospice Services. In addition, Resident #21's AHCA form 1823 documented she needs medication administration. In an interview conducted on [redacted] at approximately 11:00 AM, the Resident Care Director (RCD) stated Resident #21 only needs assistance with medications, not administration.

Class III

**0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC**

Based on observation, record review, and interviews, the facility failed to ensure 1 out of 4 residents reviewed were appropriate for continued residency (Resident #22).

The Findings Include:

During the lunch observation on [redacted] at 12:31 PM, Resident #22 was observed with a soft [redacted] on her left wrist and multiple yellowish [redacted] on her face. Resident #22 was non-interviewable. At this time, Staff C stated

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**0010** Continued From page 1

Resident #22 had a ... where she incurred the wrist ... and ... A review of Resident #22's Electronic Charting Notes revealed that on ... at 6:26 PM, Staff B noted Resident #22 had pain upon movement of her left wrist.

Review of Resident #22's AHCA form 1823 dated ... revealed diagnoses of Dyslipidemia, ... and right-injured ... Her physical and sensory limitations are documented as alert with periods of ... and an unsteady gait. Resident #22's services are listed as hospice services and medication administration. No ... precautions are listed. Her Activities of Daily Living (ADLs) are listed as independent with dressing, eating, toileting, and transferring. She needs supervision with bathing and self-care ... The AHCA form 1823 documents assistance with ambulation and notes she uses a walker.

In an interview with Resident #22's Hospice Registered Nurse (RN) on ... at 10:30 AM, she stated when Resident #22 used her walker, she would move quickly. She stated Resident #22 has not used the walker since her ... and resulting wrist ...

The Resident Care Director (RCD) stated on ... at 1:27 PM that she was out of the country when Resident #22 had a ... The RCD stated she did not have any information on the ... She did not know if an Adverse Incident Report was filed. When asked if she supervises the nursing staff, the RCD stated, 'yes.' The RCD stated she first knew of the ... and resulting hematoma Resident #22 incurred when she returned to work on ... The RCD stated she was not informed of Resident #22's wrist ...

On ... at 1:30 PM, the Administrator stated she was aware of Resident #22's ... and hematoma. The Administrator stated she did not know Resident #22 had a left wrist ... until this writer informed her of such. When asked if the Administrator thought Resident #22's needs could still be met after the ... and resulting hematoma and wrist ..., she stated she would have to look at all of the incident reports. When asked if she reviewed the prior ... documented on internal reports dated ..., ... and ..., the Administrator stated she had not reviewed them.
The Administrator stated she would need to determine if there is a certain time of day Resident #22 ... and whether they were a result of a supervision issue. The Administrator stated Resident #22 is on Hospice and the facility has 24-hour nursing staff; therefore, she believes the resident is appropriate. However, the Administrator stated she would have to trend the ... to determine what the causes are, including whether Resident #22 needs a higher level of care.
Class III

**0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC**

Based on observation, record review and interviews, the facility failed to ensure that 1 out of 7 sampled residents (Resident # 10) observed during the medication pass received his/her medications as ordered by the physician.

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**0056** Continued From page 2

The findings include:
On during medication observation 9:45 A. M., Resident #10 came by the nursing station seated in her wheelchair and asking for her medications. She was observed being accompanied by her private duty aide. The nurse, a licensed practical nurse (LPN) was then observed sanitizing her hands, retrieving the resident ' s medications from the med cart and reconciling the medication with the electronic medication observation record (eMOR). After verifying each medication, the LPN was then observed to push into a soufflé cup one after another, all the medications the resident had scheduled for the morning.

Review of the physician ' s orders, the medications packages and bottles indicated the following.
1) ER 50 MG tab. Give 1 tablet by mouth once daily
2) 137 MCG Tablet Give 1 tablet by mouth once daily
3) 0.25 mg tablet. Give 1 tablet by mouth four times daily
4) 5 mg tablet. Give 1 tablet by mouth every morning
5) 81 mg Tablet Chewable. Give 1 tablet by mouth once daily
6) 25 mg Tablet. Give 1 tablet by mouth once daily
7) ER 25 mg. Give 1 tablet by mouth once daily
8) DR 20 mg capsule. Give 1 capsule by mouth once daily 30 minutes before a meal

Further review of the medications, revealed that medication #5 and #8 had specific administration instructions that were not followed. The 81 mg tablet chewable was supposed to be chewed, but it was given to be swallowed; and DR 20 mg was supposed to be given 30 minutes before meal but it was given after meal.

During an interview with the LPN who administered the medications on at 10:00 AM, she reported that chewable medications are supposed to be chewed as indicated, and is ordered to be given before meal in order for the medication to coat the lining of the stomach before meal consumption and preventing in the stomach. However, the medication was given after the resident had breakfast.

During an interview with the resident on at 10:30 AM, she reported that she went to the nursing station before going to the dining at about 8:15 AM, but the nurse was very busy and told her to go ahead and eat first, and she would give her the medications later after breakfast. This information was also confirmed by the resident's aide present during the interview. The resident also reported that she has resided at this facility for about 7 months and that she often receives her medications either before or after meals. When the nurse is busy, she gives after meals and when she is not too busy she gives them to her before meals. However, she indicated that she has never been told to chew any medications. She also confirmed that she suffers from

Review of Resident #10's Resident Health Assessment form (AHCA form 1823) revealed that she was admitted to this facility on 2014. However, there was no indication as to whether she needed assistance with self-administration of medications or medications administration, that section of the form was left blank.

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**0056** Continued From page 3

During an interview with the DON on [redacted] at about 1:00 PM, she affirmed that chewable medications are to be chewed and medications such as [redacted] has to be given as ordered in order for it to be effective.

Class III

**0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC**

Based on observation, record review, and interviews, the facility failed to file an Adverse Incident Report, for 1 out of 2 residents' records reviewed (Resident #22).

The Findings Include:

During the lunch observation on [redacted] at 12:31 PM, Resident #22 was observed with a soft [redacted] on her left wrist and multiple yellowish [redacted] on her face. Resident #22 was non-interviewable. At this time, Staff C stated Resident #22 had a [redacted] where she incurred the wrist [redacted] and [redacted]. A review of the incident log book revealed no 1-day or 15-day Adverse Incident Report filed with the Agency for Healthcare Administration (AHCA). A review of Resident #22's Electronic Charting Notes revealed that on [redacted] at 6:26 PM, Staff B noted Resident #22 had pain upon movement of her left wrist.

The Resident Care Director (RCD) stated on [redacted] at 1:27 PM that she was out of the country when Resident #22 had a [redacted]. The RCD stated she did not have any information on the [redacted]. She did not know if an Adverse Incident Report was filed. When asked if she supervises the nursing staff, the RCD stated, 'yes.' The RCD stated she first knew of the [redacted] and resulting hematoma Resident #22 incurred when she returned to work on [redacted]. The RCD stated she was not informed of Resident #22's wrist [redacted].

On [redacted] at 1:30 PM, the Administrator stated she was aware of Resident #22's [redacted] and hematoma. The Administrator stated she did not know Resident #22 had a left wrist [redacted] until this writer informed her of such. The Administrator stated she would have filed an adverse incident report if she had known about the [redacted].
Class III

**E210 - ECC - Training - 58A-5.0191(7) FAC**

Based on record review and interviews, the facility failed to ensure that 1 out of 3 direct-care staff reviewed (Staff C) had at least 2 hours of in-service training on Extended Congregate Care (ECC).

The Findings Include:

An employee record review conducted on [redacted] revealed that Staff C, a Certified Nursing Assistant (CNA), did not have the required 2 hours of in-service training on ECC within 6 months of beginning employment. Staff C was hired on [redacted].

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**E210** Continued From page 4

In an interview conducted on [redacted] at 11:00 AM, Staff C stated she checks and changes Resident #23 frequently. This resident is noted on the list of those receiving ECC services that was provided by the Administrator. The Administrator acknowledged the missing training for Staff C on [redacted] at 3:20 PM.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
The Plaza At Pembroke Park, LLC
3535 SW 52nd Avenue
Pembroke Park, FL 33023

Dear Administrator:

This letter reports the findings of a state licensure survey with Extended Congregate Care (ECC) and Limited Nursing Services (LNS) that was conducted on , 2015 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 an on site visit 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 Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: State form 5000-3547
XG90

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