STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910662	08/28/2015
NAME OF PROVIDER OR SUPPLIER **COVENANT VILLAGE OF FLORIDA, INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **9211 WEST BROWARD BLVD PLANTATION, FL 33324**	

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

0000 Initial Comments

An unannounced Relicensure survey was conducted on 8/28/2015 at Covenant Village of Florida. The facility had deficiencies found at the time of the visit.

0025 Resident Care - Supervision

Based on observations, interviews and record review, it was determined that the facility failed to provide adequate care and supervision for 1 of 12 residents reviewed during the survey by failing to respond to calls for help in timely manner for a Resident who requires for activities of daily living. Furthermore, the facility failed to provide a means for the wheelchair bound Resident to elevate her legs when seated despite a physician ' s order to do so.
The findings include:
A) On at 9:31 AM while observing the Medication Technician/ Certified Nursing Assistant (CNA) providing medication administration assistance, the surveyor heard Resident #13 call " nurse help " three times. The surveyor informed the CNA that she should do what she would normally do when a surveyor is not present. The CNA did not go to the Resident ' s see why the Resident was calling for help, but instead asked the Care Manager to assist the Resident. The Care Manager was observed leaving the unit to go into the memory care unit to look for assistance without first checking on Resident #13. After 9 minutes had passed with no response to the Resident ' s calls for help, the surveyor intervened and asked the CNA to check on the resident who was calling for help. In response, the CNA (who was also assigned to care for Resident #13 for the shift) returned the medications she had prepared for another resident to the medication cart and then went to check on the Resident who was calling for help.
Upon the CNA ' s return from the Resident ' s , the CNA stated that she had put Resident #13 on the toilet at around 9:30 AM and instructed the Resident to call her when she was ready to be taken off of the toilet. During a 10:53 AM follow-up interview with the CNA, the CNA stated that the Resident had called her about 5 times, but that rather than stopping medication assistance to check on the Resident, she had signaled the Care Manager for assistance three times. The CNA admitted that when a Resident calls for help, she is supposed to check on the resident.

B) The surveyor summoned the registered nurse surveyor to speak with Resident # 13 regarding any possible skin redness or injury caused by being left seated on the toilet for an extended period of time. Upon entering the Resident ' s , the nurse surveyor noted the Resident dressed and seated in a wheelchair. The registered nurse surveyor identified herself to the Resident. The Resident was visibly distraught and stated " I have a lot of complaints. I just sat there forty minutes. One time I sat an hour and a half and screamed my lungs out. They have never said why it took so long. " The Resident further stated that she is fearful of falling when trying to get from her wheelchair to the bed.

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The nurse surveyor requested permission to check the Resident for signs of skin injury and the Resident consented to having the nurse surveyor check her arms and legs, declining a full skin check. The surveyor observed that the Resident ' s left and right wrists were puffy and that her sleeves had been buttoned tightly on her wrists. Upon releasing the buttons, the surveyor observed red indentations on both wrists where the sleeves had been buttoned.
The nurse surveyor observed that Resident #13 ' s legs were not supported by leg rests and were hanging down. There were no leg rests on the wheelchair. The Resident ' s toes were on the ground, but the Resident was unable to place her feet flat on the ground, as the chair seat was too high to allow her to do so. The surveyor observed that the Resident ' s right ankle was very . Upon pressing a finger on the Resident ' s outer ankle, the surveyor observed a 5-6 millimeter indentation remaining on the Residents ankle for 15 seconds after releasing the pressure. The left ankle was observed to maintain a 4 millimeter indentation for 15 seconds after relieving pressure. The Resident ' s feet were observed to be , causing her shoes to be very tight and to leave red indentations on the tops and sides of her feet. The Resident was asked how she elevated her legs to help the . The Resident replied that she had leg rests at one time, but that her foot rests had been removed and " thrown under the bed " . The Resident then pointed out a metal file box on the floor and demonstrated that she puts her feet on the file box in an attempt to elevate her legs. The Resident stated " I may be (age) years old, but I ' m not insane " .
On at 11:39 AM, a review of Resident #13 ' s records revealed that Resident #13 was admitted to the facility on / with diagnoses to include , difficulty in walking, , and . Further review revealed a faxed physician ' s order to elevate the Resident ' s legs when she is sitting. The order was signed off by the Care Manager/ RN on . Review of a / consult for Resident #13 revealed that as part of the physician ' s plan for Resident #13, the physician wrote " Keep R (right) leg elevated " . The Care Manager was present during the record review, and was asked for explanation of why the physicians ' orders to elevate Resident #13 ' s legs were not being followed. The Care Manager stated that the Resident did not want leg rests or to have her legs elevated while sitting. The surveyor asked the Care Manager to provide documentation to confirm the Resident was refusing to have her legs elevated, as well as any documentation to show that facility staff had spoken with the resident regarding the reason for the order and risks of not complying. The Care Manager stated that there was no such documentation. A subsequent review of the Resident # 13 ' s Personal Care Flow Sheets for the previous six months revealed that elevating the Resident ' s legs when seated was not listed as a task on the flow sheets.
On at 11:46 AM the nurse surveyor observed Resident # 13 in a common area seated in her wheelchair during an exercise class. The Resident ' s legs were hanging down with only her toes touching the floor.
On at 12:10 PM, the CNA was interviewed by the nurse surveyor and asked what type of care she provides for Resident #13 during her shift. The CNA replied that if the Resident " calls out "

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she puts the Resident on the toilet and then takes her off. The CNA volunteered that night shift staff gives the Resident her shower and get her dressed. She further stated that if the Resident is not feeling well she takes food to the resident ' s room. After the surveyor asked twice more if there was any other care that she provided for the Resident, the CNA stated that " she (Resident #13) does stay up in her chair with her legs up. She has a recliner. We have to help her get in it " .

On at 1:24 PM the nurse surveyor went to Resident # 13 ' s observed a small recliner in Resident # 13 ' s . The seat of the recliner was filled with 18 books, 7 DVD boxes, a magazine holder, file folders, and several cloth items. The Resident stated that she had tried to use the recliner on one occasion, but her feet extended beyond the end of the chair and that a CNA had to " pick her up like a baby " to get her out of the recliner. The Resident stated that she sits only in her wheelchair when out of bed. The Resident was observed to be seated in her wheelchair with her feet propped on the edge of a metal file box.

On at 3:00 PM Resident #13 was observed in a common area during an activity. The Resident was seated in a wheelchair with both legs unsupported and with her toes touching the floor.

On at 3:00PM Resident # 13 ' s most recent Resident Health Assessment for Assisted Living Facilities dated was reviewed. The sections of the form titled Medical History and Diagnoses, Height, and Weight were not completed. The signature areas titled Name of Recipient or Guardian and Signature of Recipient or Guardian were blank. The Resident Health Assessment form indicates that Resident # 13 is totally dependent for ambulation, and requires assistance with bathing, dressing, , toileting, and transferring. The Resident is listed as a risk in the section of the form titled Special Precautions. The section of the form titled Physical or Sensory Limitations indicates limited mobility with wheelchair use at all times. Nowhere on the most current Resident Health Assessment is there mention of elevating the Resident ' s legs when seated.

On / additional documents were requested and subsequently received from the facility. A review of the facility grievance log for the past six months revealed one resident complaint regarding a delay in responding to a call light was recorded on / .

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation, interviews and record review, the facility failed to ensure that 1 of 12 sampled residents (Resident #13) was treated with dignity during toileting.

The findings include:

On at 9:25 AM during medication pass observation, a resident (Resident #13) was overheard calling " Nurse! " While standing next to the certified nursing assistant (CNA) also a medical technician

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(med tech) who was then preparing to give medications to another resident (Resident #9), it was observed that she did not react to the call. After three subsequent calls for help, of which one was acknowledged and two respectively ignored, coming from Resident #13 ' s , this writer intervened and advised her to address that concern as she would normally do if this surveyor was not present. However, the med tech continued the med pass process ignoring any subsequent calls for assistance coming from the resident 13 ' s .
At 9:31 AM, rather than checking on the resident, she verbally notified the Care Manage of Resident #13 ' s need for assistance by stating to her, with no urgency that Resident # 13 " needed help in the ".
Then, at 9:40 AM, the nurse entered Resident #9 ' s begin to assist her with her medication. However, she was immediately stopped and was asked to check on the status of Resident #13 located a few doors away from her before proceeding. As she discontinued the med pass process and headed toward the other resident, this writer requested the assistance of a female surveyor to check on to physical condition of Resident #13. However, she reported back that the resident refused a skin assessment. Meanwhile, the resident reported to her that she was left on the toilet for about forty minutes. The resident further reported to that surveyor that she was afraid to get up because of her history. And, she added that she had in the past been left on the toilet for over an hour.
During an interview with the med tech immediately before continuing med pass at around 9:40 AM and returning to Resident #9 ' s , she was asked how long the resident was in the . She reported that she helped the resident in at about 9:30 AM. However, it is estimated that the resident was in the 9:25 AM the time med pas observation started with that staff member.
During another interview with the med/tech at 10:53 AM, after the morning med pass, she said the resident would usually sit on the toilet for about twenty minutes and then she would call for assistance when she is done. Meanwhile, she acknowledged that the resident did call for help about 5 times. She continued and said, that she had informed the nurse manager three times to come and assist ... however, no one came. She additionally confirmed that she was the one who assisted the resident to the she was pulled away to do the med pass. She said that she had just put the resident in the she came to begin med pass. She admitted that routinely when a resident call for help, she is supposed to check on the resident which she failed to do.
During an interview with the Nurse Coordinator on / at 12:17 PM, she too confirmed that she did acknowledge the med tech ' s request for help while she was doing the med pass. She said that as she was half way down towards her, she heard her saying that Resident #13 needed help to come out of the ; then, she returned and went back to the get another CNA to assist her. She indicated that as healthcare professionals, their priority is to respond to the all residents care needs; and even a CNA needs to understand that. She further reported that when she called the med tech to come and do the med pass, she found her in the hallway and informed her. She said that the med tech did not tell her that she was busy with another resident nor did she ask whether she was busy.
Review of Resident #13 ' s health Assessment (AHCA form 1823) revealed that it was completed on

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7/28/2015. The assessment indicated that she has limited mobility, she requires a wheelchair at all times, she is at risk for and needs for all activities of daily living (ADL), services to be provided by the CNAs.

Class III

0056 Medication - Labeling and Orders

Based on observation, interview and record review, the facility failed to ensure that a resident ' s medication (Resident #9) was administered as ordered by her physician.
The findings include:
During assistance with self-administration of medication on at 9:25 AM by an unlicensed staff , the certified nursing assistant/ medical technician (CNA /med tech) was observed assisting Resident #9 with her medications. She was observed opening the medication observation record (MOR), sanitizing her hands, opening the medication cart, and retrieving the resident ' s medication packages. She then checked and rechecked each medication then poured some water in a plastic cup and entered the resident ' s a smaller plastic cup in her hand, the medications and the water. She then greeted and informed the resident that she was going to give her morning medications. As she read the note on the package, she pushed into the small cup each pill as the resident witnessed. Then, the resident took the cup and emptied all the meds into her mouth and swallowed them with water. After ensuring that the resident had swallowed the pills, the med tech returned to the med cart and signed the MOR.
However, while reconciling the medications given with the MOR, it was noted that the med tech had given the following medication incorrectly: Riperidone or .
1) On the package was indicated 0.50 mg tablet. Take one tablet by mouth at bedtime
2) In the MOR the indication was as follow: 0.25 mg tablet. take one tablet by mouth in the morning and 0.50 mg at night
3) The physician ' s order revealed 0.25 mg tablet QAM (in the morning), and 0.5 mg 1 tab po QHS (at night).
After pointing out the discrepancies to the med tech, she agreed and immediately contacted the nurse coordinator who then called the doctor. The doctor then gave a verbal order as per the nurse coordinator to alternate the dosage for that day only. Consequently, the resident would receive the morning dose at night and the regular order would be resumed the following day.
Review of Resident # 9's health assessment on revealed the following diagnoses (Fibrilation, , and). The record further revealed that she needed assistance with self-administration of medication, that she is alert but has periods of .
A subsequent observation and attempt to talk with the resident later that day at about 2:30 PM could not be completed; Resident #9 was in her .

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Class III

0078 Staffing Standards - Staff

Based on interview and review of the staff personnel records the facility failed to ensure that 1 out of 2 staff members (Employee B), submitted an annual statement from a physician, indicating that the person was free from ( ).

The findings include:

A record review of Employee B's personnel record revealed her date of hire was . Further review revealed Employee B's last statement from her physician is dated for . Employee B's file lacked current documentation from a physician indicating the employee is free from .

In an interview with ALF Coordinator on at approximately 12:35 PM, she stated Employee B does not have a completed current statement for 2015. At 12:35 PM, she acknowledged the findings.

Class III

0081 Training - Staff In-Service

Based on record review and interview, it was determined the facility failed to ensure that all staff members had completed the required in-service trainings within 30 days of hire, for 2 out of 2 sampled staff records reviewed (Staff A and Staff B).

The findings include:

a) Record review of Staff A's personnel record revealed her date of hire was / / . Further record review revealed Staff A's file lacked documentation indicating the employee had completed the following in-service trainings: Elopement and Incident Reporting.

b) Record review of Staff B's personnel record revealed a date of hire of 12/ / / .
Further record review revealed Staff B's file lacked documentation indicating the employee had completed the following in-service training: Incident Reporting.

In an interview with the ALF Coordinator on at approximately 12:35 PM, she acknowledged the findings. She stated no further documentation was available for review.

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Class III

0086 Training - ADRD

Based on record review, observation and interview, the facility failed to ensure that 1 out of 2 sampled staff (Staff B) had documentation of 4 hours of training on and Related Level II (ADRD).

The findings include:

On at approximately 11:30 AM through 2 PM, observations revealed Staff B providing assistance to residents in the facility's Memory Care Unit.

A record review conducted on revealed Staff B's hire date as . Further review revealed Staff B's file had no documentation indicating completion of 4 hours of training in ADRD Level II within 9 months of employment.

In an interview conducted on at 12:35 PM, the ALF Coordinator acknowledged the findings and stated no further information was available.

Class III

0090 Training -

Based on record review and interviews, the facility failed to ensure that 2 out of 2 sampled staff (Staff A and B) had documentation of 1 hour of training on the facility's policy and procedures regarding ( ).

The findings include:

A record review conducted on revealed Staff A's hire date as // and Staff B's hire date as . Further review revealed the files had no documentation indicating completion of 1 hour of training in the facility's policy and procedures regarding within 30 days of employment.

In an interview conducted on at 12:35 PM, the ALF Coordinator acknowledged the findings.

Class III

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0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview, it was determined that the facility failed to provide a clean and hazard free living environment for 3 of 12 residents observed during the survey by failing to establish a system for auditing the cleaning frequency of the residents ' assistive devices, and by failing to monitor resident for maintenance or housekeeping needs, specifically cleaning of soiled or odorous carpeting.
The findings include:
During a tour of the facility on the following were observed:
1) Resident # 13 ' s numerous large black stains on the carpeting.
2) Resident # 13 ' s wheelchair was soiled with brown build-up noted on the wheel casements and bars supporting the chair seat.
3) The grab bar to the right of Resident #13 ' s toilet was smeared with a sticky brown substance.
4) A resident a strong -like odor coming from the entry hall. The odor was detectable from the hallway outside of the .
5) Resident # 14 ' s wheelchair had a thick white substance on the left arm rest. The brake handles were caked with a brown substance.
6) A ceiling tile in the women ' s the common area has a large rust colored stain with a 2 inch by 2 inch black area of bio growth noted in the center of the stain. CAN #A confirmed that residents are sometimes taken to this .

On a 12:43 PM a facility tour and interview were conducted with the Director of Facilities Management (DFM). The director of Housekeeping was unavailable for interview. The DFM confirmed the above findings. The DFM stated that " the carpet needs to be replaced " . The DFM further stated that the stain on the common area ceiling tile was caused by condensation from the air conditioner. The DFM stated that there is a capital improvement plan that will include renovation of the facility at some point during the next ten years. The DFM stated that if nursing staff notice a maintenance issue they are to call it to the maintenance department and the issue will be entered into a maintenance software system that would then generate a work order. The DFM stated that there is no audit tool in use or routine inspection conducted of resident by the maintenance department.
On at 1:12 PM an interview was conducted with the Lead Housekeeper in the presence of the DFM. The Lead Housekeeper was asked to provide the surveyor with the cleaning schedules or logs for the facility residents ' wheelchairs and other assistive devices. The Lead Housekeeper stated that there is a cleaning schedule for the long term care facility patients ' wheelchairs but none for the wheelchairs of the assisted living facility residents. He offered that if the chairs needed to be cleaned the nursing staff can bring them outside on designated days to be cleaned by the housekeeping staff. He confirmed that there is no schedule audit tool in place or any method to assure the cleanliness of the residents ' assistive devices.

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Class III

0162 Records - Resident

Based on observation and interview, it was determined that the facility failed to maintain a copy of the Resident ' s contract with the assisted living facility, for 1 of 1 resident records reviewed.
The findings include:
On :05PM a review of facility records for Resident #13 was conducted. Upon reviewing the Resident ' s documents, the surveyor was unable to locate the Resident ' s contract with the Assisted Living Facility. The Care Manager was requested to assist in locating the contract. The Care Manager stated that the facility is a continuing care community and that the Resident had come to the assisted living facility from the independent living facility on the same grounds. The Care Manager stated that because the Resident had previously lived in the independent living facility there is no Resident contract specifically for the Assisted Living Facility. The Care Manager was asked to provide any contract on file at the facility that identifies Resident #13 as an Assisted Living Facility resident. The Care Manager made several phone calls to other staff members but none produced a contract.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Covenant Village Of Florida, Inc.
9211 West Broward Blvd
Plantation, FL 33324

Dear Administrator:

This letter reports the findings of a State Relicensure Survey that was conducted on , 2015 by a representative from 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than 24, 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 Mayo-Davis
Field Office Manager

AMD/jw
Enclosure

XG90

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