STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964664	09/25/2015
NAME OF PROVIDER OR SUPPLIER ARDEN COURTS OF DELRAY BEACH	STREET ADDRESS, CITY, STATE, ZIP CODE 16150 JOG RD. DELRAY BEACH, FL 33446	

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

0000 Initial Comments

An unannounced Relicensure survey with Limited Nursing Services (LNS) was conducted on 09/24/2015 - 09/25/2015 at Arden Courts of Delray Beach. The facility had deficiencies found at the time of the visit.

0010 Admissions - Continued Residency

Based on observation, record review and interviews, the administrator failed to monitor the continued appropriateness of residence in this assisted living facility (ALF) for 2 out of 3 sampled residents (Resident #2 and #24). This is evidenced by the facility failing to have an interdisciplinary plan of care coordinated and implemented in consultation with hospice and the facility to address the additional care needs and to ensure the services were provided for each resident.

The findings include:

a) On at 10:00 AM, the administrator stated during interview that there were no residents at the facility who had pressure sores. However, during interview with the Agency nurse at 1:00 PM based on observations of Resident #2 with the facility's LPN, she stated Resident #2 currently had a pressure on her , that she had observed on this date, .

Review of the record revealed the resident had a pressure with care to her documented on the following physician's orders:

1) , "Cleanse with normal , apply mepilex (foam dressing) every 3 days
2) , "Discontinue previous care order. Cleanse to with cleanser, cover with foam dressing 3 times weekly and as needed"
3) , "Discontinue previous care to : cleanse to with cleanser, cover with foam dressing 3 times a week and as needed".

Additional hospice Communication Visit Notes indicated the following:

1) , "Routine care visit completed, updated facility nurse"
2) , " care documented, facility nurse updated"
3) , " care documented, facility nurse updated"
4) , " care documented as completed"
5) , " care documented as completed"
6) , " care documented as completed"

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The hospice plan of care with a start date of was in the resident's record, but did not indicate additional care instructions for facility staff to adhere to in order to prevent pressure sores or to enhance the healing of the current pressure . The resident's health assessment (AHCA Form 1823) dated / documented " care/ " under nursing treatments/services and "total care" for ambulation. The assessment also noted "yes" indicating the resident had a pressure , but did not include an explanation of the pressure in the comments column.

Facility record review revealed that on , the resident had been transferred to the hospital for a hip . She returned to the ALF on with a Clinical Evaluation showing the resident had "Pressure (bedsore) to noted to the . A Body Assessment Tool dated also had a to pressure documented and marked on a body diagram on the . An additional hospice order for " care" to the " " was dated , upon the resident's return from the hospital.

During further interview with the administrator on at 1:00 PM, she stated that she did not know about the resident's pressure . The monitoring of appropriate residency in this ALF with ensuring additional services are provided as needed in conjunction with hospice staff was discussed.

b) On at 9:10 AM, Resident #24 was observed laying in bed on her back with the head of the bed slightly elevated. Upon introduction, the resident only stated, "I can't see" twice, but had her eyes open. The hospice aide was present and began to feed the resident, who opened her mouth each time she finished swallowing a spoonful of the pureed breakfast meal. The aide was asked what the resident's schedule was. She stated the resident is in bed every day when she was with the resident (5 days a week, for breakfast and lunch) and that she did not know what she did the rest of the time. She said she had been visiting the resident for 2 months. She stated the resident likes to sleep so she turns off the light after breakfast and allows the resident to rest. Observation of the resident's a rolling walker in the back of the resident's closet. There was no wheelchair in the resident's . The resident was again observed on at 12:00 PM and 2:00 PM in the same position in bed with her eyes open, facing the outside window, lights off, and no television or music.

On at 1:30 PM, a hospice doctor stated during interview that the resident "spent a lot of time in bed" and had been for an unknown amount of time due to "red areas" she had developed and "bad core stability". She stated the resident was "immobile" and "cannot walk" but is not bedbound, and "should be towards the end of it (time spent in bed)". She stated the resident is given (medication) at 8:00 PM "for sleep".

During interview with the resident's representative on at 2:30 PM, he stated he saw the resident at various times 2 to 3 times a week and said she "has not been out of bed for at least a few months".

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During interview with the administrator on 9/25/15 at 12:45 PM, she stated the resident was out of bed at least once a few weeks ago that she knew of. The interdisciplinary care plan to address the resident's care needs as a bedridden resident were requested. The hospice plan of care for start of care beginning was reviewed and included the following to address the resident's total care needs for ambulation, transfers, dressing, bathing, eating, and toileting:

1) Home Health Aide provided 5 times a week for 4 weeks; 4 times a week for 1 week; 2 times a week for 1 week.
2) Skilled nurse visits 2 times a week for 4 weeks; 4 times a week times 1 week.
3) Chaplain visit 1 time.

A plan of care for staff at the facility to follow, related to the resident's total care needs with interventions to prevent further , provide socialization, provide activities, assist with exercise (passive or active range of motion) and to address care could not be identified in this plan of care. There was no indication that what was identified as the "plan of care" had been developed and implemented in consultation with the facility. The administrator was not able to identify the resident's individual care needs in the hospice "plan of care".

Review of the resident's health assessment (Form 1823) dated showed the resident's diagnoses as , , and Memory Loss. Her congnition and behavioral status listed "diminished cognition". Physical or sensory limitations were documented as "memory loss, decreased ability with ADL's (activities of daily living), advanced ". All ADL's on page 2 indicated the resident required "total care". In the "comments" section where the type of assistance or care is to be documented, there was only "by hospice" or "by staff" listed with no details about the frequency or extent of care.

Although, Resident #24 was determined to be ill and was admitted to hospice with a start of care date on , the resident's extensive care needs and bedridden status, total care with all ADL's deemed this resident inappropriate for continued residency at this ALF due to the facility failure to develop an interdisciplinary plan of care that was coordinated and implemented in consultation with hospice and the facility to address the additional care needs and to ensure the services were provided .

These findings were discussed with the administrator during interview on at 1:30 PM. She confirmed she had not given a 45 day notice of relocation to Resident #2 or #24. She stated she had not determined either of the residents were inappropriate for continued residency in this ALF. The administrator also confirmed that she didn't have documentation indicating the coordination of care and services in conjunction with Hospice for both residents to ensure continued residency either; she stated no additional information was presented at this time.

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Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation, interview, and record review, it was determined the facility failed to ensure that each resident had convenient access to a telephone to facilitate each resident's right to unrestricted and private communications on all 4 units and the common areas of this facility (Country Lane; Garden Path; Cottage Place; and Boathouse Cove).

The findings include:

During tour of the Evergreen Way Unit conducted with the ED (Executive Director), on beginning at approximately 9:30 AM, she was asked where a convenient, unrestricted, and private telephone was provided for resident use. The ED pointed out the wired telephone located at the caregivers work desk area that is located in the kitchen area, adjacent to the dining the living . She was asked how a resident would make and/or receive a private phone call in this location. She admitted that this was not a private location. She stated they have tried portable phones but they get lost so they don't use them anymore. She stated that residents could use the phone in the wellness center. She was asked if a resident would be left alone (for privacy) in the wellness center where all of the resident's charts are maintained. She stated no they would not. The ED stated they could lock a cell phone on the nurse's cart. She was asked if that was convenient for resident use. She acknowledged that it was not. The ED acknowledged that the facility does not currently have a method in place for residents of this facility (all 4 units: Country Lane; Garden Path; Cottage Place; and Boathouse Cover are designed in the same manner) to conveniently make or receive private telephone calls. The ED stated there would only be a couple of residents in this secured facility that could even converse on the phone. She was reminded that the rights of all residents need to be observed including their right to privacy, regardless of the resident's abilities.

During subsequent interview and record review with the ED, on beginning at approximately 8:45 AM, she was asked for the facility's policy related to resident use of telephones. She stated the only thing that she was aware of was in the Resident Handbook that is provided upon admission. The Personal Telephone section indicated the following: Many people with memory have difficulty using the telephone appropriately. Therefore, telephones are not provided in resident . Telephone are provided in a central location in each house. If you would like a personal telephone for your loved one, you may make the necessary arrangements with the local telephone company for installation and billing
The ED acknowledged that this policy does not address how the facility provides convenient,

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unrestricted and private access to a telephone for all residents of the facility.
Class III

0053 Medication - Administration

Based on observation, documentation review and interview, the facility failed to ensure that medications were administered to residents according to the physician orders and the established policy. This affected 2 of 5 residents observed during medication pass observation on (Residents #1 & #2).
The findings include:
Review of the policy titled Protocol for Administering Medications, Under General Instructions, revealed the following: Administer medications in accordance with frequency prescribed by physician, i.e., within 60 minutes before or after prescribed dosing time.
During an interview with the nurse on duty on / at approximately 9:35 AM, she revealed that she and one other nurse administers the medications to residents as there are no med techs working here.
1. Review of the file for Resident #1 revealed the physician had ordered 0.25 mg twice daily ( ). The Medication Observation Record (MOR) documented the times of administration as 7 AM and 7 PM. Observation during the medication observation pass revealed the nurse administered the medication (med) at approximately 9:40 AM. She said the resident is not out of bed at 7 AM, so the time should really be changed. She said that medications should be administered an hour before or after the time indicated on the MOR. There was no other reason given why the medications were not administered during the required time frame.

2. Review of the file for Resident #2 revealed the physician ordered 325 mg daily, 10 mEq daily, 40 mg daily, 20 mg daily, Oyst-cal 500 mg daily, Therems-M one daily, D-1000 mg daily and 100 mg daily. Review of the MOR revealed the time for the morning med administration was 8 AM. Observations during the same medication observation pass revealed the same nurse administered the medications at 9:53 AM. There was no justification for why the medications were provided outside the required time frame. The nurse said she administers medications to residents on 2 of the 4 units in the facility and the night-nurse administers meds to the other 2 units.
Further record review and observation revealed for Resident #2, there were three medications that were not available for administration (25 mg twice daily, 5 mg daily and 10 mg daily). The Ability was ordered by the physician on ; the was ordered on admission (/) and there was no order in the chart for the Metropolol. The nurse was not sure when or if these 3 medications were reordered from pharmacy. The surveyor requested a copy of the fax for the re-ordering of the medications (, &) to the pharmacist from the administrator and another Licensed Practical Nurse on 3 occasions during the day of survey. However, the facility

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provided no additional documentation as requested.

During an interview with the Administrator, aforementioned was acknowledged, no further documentation was available for review.

Class III

0054 Medication - Records

Based on observation, documentation review and interview, the facility failed to ensure they maintained an accurate medication observation record that was updated with medications taken, any missed dosages or refusal and potential medication errors, immediately each time the medications was offered or administered. This affected 3 of 5 opportunities for medication pass observation on and affected Residents #2, #21 and #23.

The findings include:

Review of the facility's policy regarding Protocol for Medication Administration revealed the following: If a medication is not administered, the nurse will enter initials in the space allocated on the medication; Circle initials indicating that the medication was not given; Provide written rationale regarding why the medication was not given or refused in the designated area on the MAR or in the service notes; and Notify the physician when indicated.

Review of the facility's policy regarding Reordering Medications revealed the following: Medications are reordered by a licensed nurse when a 5-day supple remains or as coverage allows. The Procedure included: All routine solid oral tablets or capsules medications are automatically refilled on a 28-day cycle....To reorder non-cycle medications: Peel off 2-part pharmacy label from medication, Place label on re-order sheet, Fax re-order sheet to pharmacy, Place original re-order sheet in medication verification delivery folder located at Health Center; and The nurse notifies the Pharmacy in the event that a reordered medication needs to be received within a 24 hours period or before the next scheduled delivery.

1) Review of the file and medication observation record (MOR) for Resident #2 revealed; 10 mg every AM was ordered (physician ordered on admission of /). On , the physician re-ordered 10 mg every morning/AM. Review of the MOR revealed no evidence the was provided from 1 through , , 2015, on . There was no documentation or evidence as to why the medication was not administered at the above times and no

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evidence the physician was notified. During the medication observation pass conducted on 9/24/15 at approximately 9:50 AM, the nurse initialed and circled the box for and documented 'Not Available, Will contact pharmacy'.

Further review of the physician orders for Resident #2 revealed 5 mg daily was ordered by the physician on and reordered on /. Review of the MOR for 2015 revealed the medication was not administered to the resident from 1st to present. There was no documentation or evidence as to why the medication was not administered at the above times and no evidence the physician was notified. During the medication observation pass, the nurse did not administer the medication to the resident as it not available.

Further review of the physician order dated and the MOR revealed ' (, an) 25 mg take one tab orally mouth two times a day (8 AM & 5 PM on MOR). There was no evidence on the MOR that was administered from / to or at 5 PM on . During the medication observation pass on at approximately 10 AM with the nurse, it was not administered and the nurse documented 'Not Available, Will contact pharmacy'. Further review of Resident #2's file with another nurse revealed there was no evidence of a physician order for the . Later on , the physician order was located on 'Physician Move-In orders' form that was dated . Interview with the nurse following the medication observation pass revealed she did not know why the medications were not provided on prior days as she has only worked at the facility for 3-4 days.

2) On , the 2015 Medication Record for Resident #21 was reviewed and the following omissions were identified:

a) 20mg-a horizontal line drawn (rather than staff initials) for 8:00 AM dose on / , and .
b) 100mg-a horizontal line drawn (rather than staff initials) for 8:00 AM dose on / , and .
c) XR 14mg-a horizontal line drawn (rather than staff initials) for 8:00 AM dose on / , and .
d) Therapeudic M-a horizontal line drawn (rather than staff initials) for 8:00 AM dose on / , and .
e) Polyethylene 17gm-a horizontal line drawn (rather than staff initials) for 8:00 AM dose on / , / , and .
f) Citracal Petites-a horizontal line drawn (rather than staff initials) for 8:00 AM dose on / .
g) ER 500mg-a horizontal line drawn (rather than staff initials) for 8:00 PM dose on and a blank box on .

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h) -S-blank for 8:00 AM dose on .

3) On 9/24/15, the 2015 Medication Record for Resident #23 was reviewed and the following omissions were identified:

a) 70mg-blank for weekly dose on / .

These findings were acknowledged by the administrator during interview on at 2:00 PM. The administrator acknowledged that the Medication Records had not been initialed by the licensed nurses at the facility each time the residents were administered their medication on multiple dates and times.

Class III

0162 Records - Resident

Based on observation, documentation review and interview, the facility failed to ensure it maintained a copy of physician medication orders in the resident's record at the time of the survey conducted on for one (1) of 5 sampled residents during medication observation pass. This affected Resident #2.

The findings include:

Observation during the medication observation pass conducted on at approximately 9:50 AM revealed ( ) on the Medication Observation Record (MOR) was not administered to Resident #2 by the nurse. The nurse documented it was not available. Review of the clinical file with another nurse and the administrator present revealed there was no order or copy of the order located for the medication . Later in the day, the nurse still had not located a copy of the physician order.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Arden Courts Of Delray Beach
16150 Jog Rd.
Delray Beach, FL 33446

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 19, 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

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com