STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968725	10/01/2015
NAME OF PROVIDER OR SUPPLIER **GREEN LIFE ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **840 SW 8TH STREET** **POMPANO BEACH, FL 33060**	

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

0000 Initial Comments

An unannounced Limited Nursing Services monitoring visit was made to the Green Life Assisted Living Facility on 09/30/2015. There were deficiencies found at the time of the monitoring visit.

0031 Resident Care - Third Partv Services

Based on observation, interview and record review, the facility failed to provide documentation of on-going communication between the home health agency providing care for the resident (Resident #1) and facility staff, for 1 of 2 residents reviewed for coordination of care and services between the facility and a third party provider. This practice left the facility without current documentation of the general condition of a for which Resident #1 was being treated.

The findings include:

Resident #1 was admitted to the facility on with diagnoses to include , , and late effects of . On the resident was seen by an advanced practice registered (ARNP) nurse and subsequently hospitalized for treatment of a left measuring 3.0 centimeters (cm) by 2.0 cm by 0.4cm. The ARNP progress note contains the following: " Treatment Plan- since patient is living in an assisted living facility he needs to be hospitalized secondary to his wounds. " Upon return to the facility, an order for care to be provided by a home health agency was obtained for Resident #1.

During a /15 record review, the registered nurse surveyor was unable to locate documentation of visits by the home health agency (HHA) nurse during the month of in either the Resident's home health agency folder or facility chart. There was no documentation of communication between the HHA nurse and facility staff concerning Resident #1 for the month of . During an interview on /15 at 1:40 PM interview, the facility manager stated that Resident #1 remains under the care of a home health agency nurse. The facility manager stated that if she is at the facility after 6 PM on the days that the nurse comes to see Resident #1, she receives a verbal report on the Resident's condition. During a telephone interview on / , the HHA nurse stated that she saw Resident #1 twice a week for care and/or observation during the month of 2015. The HHA nurse stated that the appears healed at this time and that she is observing it twice a week as the Resident continues to experience tenderness in the area of the . The HHA nurse stated that she cannot provide documentation of having communicated with facility staff about Resident #1's condition during the month of , as of the date of the interview. The HHA Director of Nursing (DON) was interviewed by telephone on /15 and was also unable to provide documentation of written or verbal condition reports regarding Resident #1's being given to facility staff during the month of .

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During a review of the facility's policies and procedures manual a form titled 'Policy and Procedure Third (3rd) Party Providers- Services Rendered' was found to be in the manual. A copy of the policy was obtained. Included in the policy were the following:
It is the policy of this facility to adhere to the following procedures when allowing for 3rd Party Provider Services at this facility:
B. Upon arrival you must come into the office and sign in on the appropriate form and include the following:
1) Name of the Resident being seen
2) Type of services being rendered
3) The duration of the visit
C. The 3rd Party Provider will provide the facility with a written progress report (Form to be provided by facility) on each resident being seen on a weekly basis.

During an interview on /, the facility manager admitted that the facility ' s 3rd party provider policies as listed above are not being followed. The facility manager further revealed that she was unaware of the policy and that the facility does not have a form to provide to 3rd party providers for use to provide the facility with a weekly written progress report. This is in conflict with the facility ' s own policy.

On /15 two registered nurse surveyors observed the on Resident #1's left . A 2cm by 1cm closed area with raised, pink tissue (also known as tissue) was observed on the Resident's left . Also observed was a darkened area of the same size above the granulated tissue. In the Resident ' s fold, a 2 ½ cm by 1 cm pink raised area which had the appearance of a healed was also noted. The Resident states that he still feels some discomfort when sitting on a hard surface in the area of the healed .

Class III

0055 Medication - Storage and Disposal

Based on observation and interview, it was determined that the facility failed to safely store medications scheduled for return to the dispensing pharmacy by leaving the door to the medication the pharmacy return bin was located open and potentially accessible to residents. The facility also failed to properly secure used hypodermic needles by leaving an overflowing sharps container in an unlocked . These practices have the potential to affect all residents living at the facility. Furthermore, the facility failed to properly dispose of abandoned medications for two discharged residents.

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The findings include:

1) During a 10/01/15 limited nursing services (LNS) monitoring visit to the facility, the registered nurse surveyor was touring the building with the facility manager and a second registered nurse surveyor. At 9:35 AM, while passing through the dining and television area, the surveyor observed that the door to an office area at the end of the dining standing open. A sign on the door read "Nursing Station ". At the rear of the office, a second open door was observed to be standing open and a medication cart could be seen. The facility manager identified the rear most area as the medication . The surveyors and facility manager entered the medication , inside were two locked medication carts and a locked refrigerator. On the floor, a blue plastic bin with an attached two-sided fold-in lid was observed. Upon opening the blue plastic bin, the surveyor noted the bin to be filled with pharmacy packaged single dose "bingo" medication cards. The finding was confirmed by the second surveyor and the facility manager. The facility manager stated that the medications were unused medications that were scheduled to be picked up by staff from the pharmacy later that day. Photographic evidence was obtained.

Among the medications in the bin were two 100milligram (mg) tablets, 2 300mg capsules, 2 80mg tablets, and one 150mg tablet. At the time the unsecured medications were discovered there were two male residents seated in the dining area. A female resident who spoke only Spanish and was carrying a doll had followed the surveyors into the common area and was walking about the dining area.

2) While in the medication had been observed to have the door open, rendering the area accessible to residents, the registered nurse surveyor noted a red plastic container with a white screw-on lid. The lid was sitting ajar on the container. This type of container is commonly known as a ' sharps ' container and is used for the safe and sanitary disposal of used hypodermic needles and glucose lancets. An uncapped syringe was protruding from the container. The finding was confirmed by a second surveyor and the facility manager. Photographic evidence was obtained. The facility manager confirmed that the sharps container was overfilled and that the lid should have been closed on the filled container in order to protect staff members and residents from a potential needle stick.

3) The facility manager was asked to unlock the refrigerator in the medication . Inside the refrigerator were 8 multi-dose vials of , an injectable medication used in the treatment of . The building manager stated that the resident to whom the medication belonged had expired on , 2015. Also in the refrigerator was a plastic box containing a boxed vial of 100 units per milliliter , a boxed vial of 100 units per milliliter , and an unboxed vial of 100 units per milliliter . The facility manager was asked if the resident to whom the was prescribed still lived at the facility. The facility manager stated that the resident

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had expired in , 2015. The facility manager, who is also trained to assist in the self-administration of medications, confirmed that the medications had neither been returned to the pharmacy nor destroyed as they should have been.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation, interview and record review, the facility failed to provide a safe living environment, free of hazards, and ensure that all existing appurtenances are maintained in good working order for all residents residing in the facility.

The findings include:

On / beginning at 9:15 AM, an observation tour was conducted of the facility. The following was observed:

1. Fire Alarm/Security personnel were observed testing the facility fire alarm system. In an interview with the facility Care Manager at that time, she stated that the fire alarm company was conducting a repeat "annual testing" since the fire alarm panel had been struck by lightning on , causing it to . The Care Manager stated that the alarm company personnel had instructed the facility to conduct a fire watch until the fire alarm system could be repaired. The Care Manager stated that the facility staff had conducted hourly rounds from until / , when the alarm panel had been replaced but she had no documentation of the rounds. She stated that on , the fire alarm panel was not functioning properly and she had contacted the fire alarm company to evaluate her concerns.

In an interview with the fire alarm service technician on 10/1/ 2015 at 10:45 AM, he stated that he had received a call from the facility with a request to check on the fire alarm system. He stated that he had determined that when the pull stations were activated, there was no audible or visual alarm triggered to alert residents or staff. He stated that on , the fire alarm panel had been hit by lightning and the alarm system was deactivated and required to be repaired off site. He stated that he had informed the facility to conduct a fire watch which required physical checks of the entire premises, every 1 hour until the alarm could be repaired/replaced. He stated that the alarm had been replaced on / and was functioning properly until he received a call from the facility on . He stated that the fire panel was again and a fire watch would need to be conducted until the panel could be replaced. He stated that the company had been in contact with the local Fire Department regarding the faulty fire alarm.

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Review of Fire and Security Alarm company service order dated on 9/18/2015, indicated that the fire panel was in process of being tested for function when a lightning strike caused the panel to and required repair. The fire panel was removed and the fire alarm system was deactivated for the facility. Review of the order indicated that the facility was placed on a fire watch until the system main panel could be repaired. Review of Fire and Security Alarm company service order dated on / / indicated that the panel was not going into audible/visual alarm mode" or reporting signals to the control panel. The entire panel required to be repaired again.

In an interview with the fire alarm service technician and Administrator on 10/1/ 2015 at 11:00 AM, the Administrator stated that he had not notified the Fire Department of the facility fire alarm system. He stated that he though the Fire and Security Alarm Company had been in contact with the Fire Department.

In an interview with the Fire Inspector on / at 11:10 AM she stated that the Fire Department had not been informed of any issues with the facility's fire alarm system. The Fire Inspector arrived on site at 11:35 AM and conducted an investigation and interviewed the Administrator. The Fire Inspector questioned the Administrator about the Fire Watch conducted from - / and asked for documentation of the fire watch. The administrator stated that during that time, the staff had conducted hourly rounds but he had no documentation. The Fire Inspector instructed the Administrator to immediately begin conducting a fire watch of the entire premises, every 15 minutes and to document on a log, until the fire alarm system was repaired. The Administrator stated he would begin immediately with the fire watch as directed by the Fire Inspector.
Review of the Fire Department Fire Prevention Report dated on / indicated to "Correct all violations immediately and the facility was placed on Fire Watch until the system is 100%".

In an interview with the Administrator on / at 1:45 PM, he stated that he had been notified by the alarm company that the alarm panel would be repaired later that day. The Administrator stated that he was instructed by the Fire Inspector to notify her when the fire alarm had been repaired/replaced, so she could return for re-inspection of the system.

2) On / two surveyors toured the facility accompanied by the facility manager. At 10:00 AM the surveyors observed that the bathtub in a by the two residents of was in

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disrepair. Much of the white finish on the bottom of the bathtub had chipped away leaving an 18 inch by 24 inch area on the bottom of the tub where the green under-surface was largely exposed beneath the eroded finish. The area was uneven and not able to be properly sanitized due to gaps between the surfaces. The facility manager confirmed that residents currently use the bathtub to take showers. The fan in the heavily laden with dust between the intake vents.

During the same tour, at 10:08 AM, a second bathtub in a by 4 residents living in 9, 10, and 11 was found to be in disrepair. The finish on the bottom of the tub had chipped away in large pieces revealing the blue under-finish for 30 per cent of the floor of the tub. There were gaps between the white finish and the under-surface which would prevent the bathtub from being able to be properly sanitized. The facility manager confirmed that residents currently use the bathtub to take showers. Photographic evidence was obtained.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Green Life Assisted Living Facility
840 SW 8th Street
Pompano Beach, FL 33060

Dear Administrator: RE: Limited Nursing Services Monitoring Survey

This letter reports the findings of a Limited Nursing Services (LNS) Monitoring survey 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. 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 , 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 representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure
XG90

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