STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911234	10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA ON TURKEY CREEK	2800 FORDHAM ROAD, NE PALM BAY, FL 32905

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

0000 Initial Comments

A Relicensure survey with Limited Nursing Services was conducted on , 2015. Bethesda on Turkey Lake had deficie0ncies at the time of the visit.

0007 Admissions - Criteria

Based on record review and interview, the facility admitted 1 of 6 residents who exceeded ALF admission residency criteria, per health assessment report (#2).

Findings:

Resident #2's record revealed a health assessment report form (1823), dated / / , that listed diagnoses of , mood . The assessment indicated she needed total care with ambulation, toileting and transferring.

On / / at approximately 4 PM, resident #2 stated she was stilll independent in ambulation and the staff only assisted her with bathing and toileting.

On at approximately 4:30 PM, the director of nursing stated the resident, although diagnosed as a quadriplegic, had movement in arms/ hands. She was able to transfer from wheelchair to bed, was able to feed herself, and was assisted with her activities of daily living.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on record review and interviews, the facility failed to honor the resident's rights to be treated with consideration and respect and with due recognition of personal dignity and individuality fro 1 of 6 sampled residents (#2).

Findings:

Resident #2's record revealed a health assessment report form (1823), dated , that listed diagnoses of , mood .

Facility note dated / at 2:30 PM indicated a facility staff saw resident #2 driving her scooter on the side of the road, not on the sidewalk.

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Facility note dated at 7 AM indicated the resident refused to get out of bed unless she got the scooter back. Was agitated cursing.
Facility note dated read, "I gave the directive for resident not to have her scooter due to incident yesterday of leaving property. She now has her wheelchair but refused to use it, she is extremely difficult."

On / / at approximately 3 PM, the administrator stated she wrote the note dated and gave the directive to take the resident's scooter away, thinking about the resident's well-being and safety.

On / at approximately 4 PM, resident #2 stated she was upset that her scooter was taken away and wanted it back. She went out and wrote she rode the scooter on the side of the road. While she was on the property's grassy side outside, she toppled over. She now knows not to do that anymore. She was alert and oriented and knows what to do. She said she wanted her scooter back.

Class III

0052 Medication - Assistance with Self-Admin

Based on observations and interview, the facility failed to ensure the unlicensed staff who assisted 1 of 6 sampled resident (#6) with self-administration of medications followed the correct procedure (E).

Findings:
Observation on / / at approximately 12 PM during the medication pass noted that staff E wore gloves. Resident #6 sat by her as well as another caregiver. Staff E stated, "I am giving you the pain pill and your C. I know you like them with apple sauce." Staff E put the pill in apple sauce and held the resident's hand to bring it to her mouth with the assistance of the other staff. She then put the C pill in the resident's hand and the resident took the pill. The resident said she was able to chew that one. Staff E then signed the Medication Observation Record.

On / / at approximately 4:30 PM, the director of nursing was informed of the finding.

Class III

0078 Staffing Standards - Staff

Based on record review and interview, an unlicensed personnel administered medication which was not consistent with her level of education, training, preparation, and experience to a resident (E).

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Findings:

Observations on at approximately 12 PM during the medication pass noted that staff E told Resident #6, "I am giving you the pain pill and your C. I know you like them with apple sauce." Staff E put the pill in apple sauce and held the resident's hand to bring it to her mouth with the assistance of another staff.

Resident #6's record revealed a health assessment report (1823), dated , that listed diagnoses of Legally , Non- and expressive aphasia. Per the 1823 report, the resident needed assistance with medication administration.

On / / at approximately 5 PM, the director of nursing confirmed that unlicensed staff E assisted resident #6 with self-administration of medication, not the nurses.

Class III

0085 Trainina - Nutrition & Food Service

Based on interview and staff training certificates, the food service manager, responsible for the facility's food service and the day-to-day supervision of food service staff, failed to completed a minimum of 2 hours continuing education each year in topics pertinent to nutrition and food service in an assisted living facility that was provided by a certified food manager, licensed dietician, registered dietary technician or health department sanitarians.

Findings:

On / at approximately 11:45 AM, the Food Service Manger stated she was responsible for the facility's food service. She said she provided a copy of her last 2 hour food service training at the time and it was dated . The Food Service Manager stated she had not attended 2 hours of continuing education since / / .

On at approximately 5 PM, the administrator confirmed the finding.

Class III

0091 Trainina - Documentation & Monitorina

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Based on review of personnel files and interview, the facility failed to ensure certificates included the number of hours of the training program for 1 of 4 sampled staff (#A).

Findings:

Staff #A's personnel record revealed she was hired on / /. The certificates of in-service training for Elopement Response policies and procedures, Resident Rights, Recognizing , Neglect and , Incident Reporting, and Safe Food Handling were dated / / . The certificates did not indicate the number of hours of the training program.

On / at approximately 4:30 PM, the director of nursing confirmed the findings.

Class

0093 Food Service - Dietary Standards

Based on menu review, observations and interviews, the facility failed to date the menus that were planned and served, maintain the last 6 months of menus, to ensure no more than 14 hours elapsed between the end of an evening meal containing a protein food and the beginning of a morning meal, and did not store at all times a supply of water sufficient for drinking to be used in the event of an emergency for the 78 residents of the facility, and did not have a plan for obtaining water that was coordinated with and reviewed by the local disaster preparedness authority.

Findings:

1. On / / at approximately 11:35 AM, the assistant food service manager stated the meals were served as follows: Breakfast at 7 AM - ' ' meal, 7:30 AM - hot meal; Lunch from 11:45-12 PM; Dinner at 4 PM. Fifteen (15) hours and 30 minutes elapsed between the end of the evening meal and the start of breakfast the next day. The assistant food service manager stated he was not aware of the requirement of no more than 14 hours between meals.

2. Review of the menu posted by the facility revealed that they were not dated. Written on the board for lunch was pork chops, rice pilaf, vegetable, bread, and dessert. It did not note the type of vegetable and dessert to be served. Review of the menu identified to be in use by the dietary manager revealed chicken Tahititian, rice pilaf, oriental vegetables, dinner roll, and green under sea dessert.

Review of the menus revealed the only menus available for review was dated for . There were no dated menus available for review for the last six month.

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On / / at approximately 11:35 AM, the food service manager stated he did not have the dated menus for the last six month. He said they used cycled menus and did not date them. They would just rotate the menus.

3. Review of the emergency food supply revealed only 32 gallons of water. Two hundred thirty four (234) gallons were required, 1 gallon x 3 days x 78 residents.

On / at approximately 1 PM, the dietary manager stated the facility only had 32 gallons of water and tney nad plan to obtain water from a local company for emergencies, which was included in their disaster plan.

Review of the letter from the company revealed it noted the following. The letter was dated / . The name of the company was noted and read, "Will make every effort possible to supply your accounts with food and water supplies. Please make secondary arrangement on water supplies as we do not have the capacity to store enough water."

Class III

0152 Phvsical Plant - Safe Livina Environ/Other

Based on observations and interviews, the facility failed to provide and maintain a home-like and decent environment in which to provide for the safe care residents.

Findings:

During the facility tour on at approximately 9:30 AM, a strong and pungent odor of was noted by .

On / at approximately 2 PM, staff F stated housekeeping cleaned the the resident on the carpet. The smell of was on the rug.

Observations noted the Breezeway Alcove, a place residents congregate and walk by, had brown stains on the ceiling and around the window.

On at approximately 5 PM, the director of nursing confirmed the findings..

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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0167 Resident Contracts

Based on record review and interviews, the facility failed to ensure the resident contract for 2 of 2 sampled resident records contained all the required components (#1 & 2).

Findings:

Review for Residents #1 and #2's contracts did not contain a provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), Florida administrative Code, and every 3 years thereafter, or after a significant change.

On / / at approximately 3 PM, the administrator confirmed the findings.

Class

N277 LNS - Resident Care Standards

Based on resident record review and interview, the facility failed to ensure that nursing services conducted and supervised in accordance with 464 Florida Statute and the prevailing standard of practice in the nursing community.

Findings:
Florida Board of Nursing, Nurse Practice Act, 464.003 (3)(a)(1)(2), states that the practice of professional nursing means the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of , biological, physical, and social sciences which shall include, but not be limited to: (1) the observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care; health teaching and counseling of the ill, injured, or informed; and the promotion of wellness, maintenance of health, and prevention of illness of others, (2) the administration of medications and treatments as prescribed or authorized by a duly licensed practitioner authorized by the laws of this state to subscribe such medications and treatments.

On / / at approximately 1 PM, the director of nursing (DON), a licensed practical nurse (LPN), stated she and another LPN conducted the monthly nursing assessments and a registered nurse (RN) co-signed them. She added any nurse will do the assessments and the RN co-signs them.

Review of the Limited Nursing Services facility binder revealed a monthly nursing assessment dated / that indicated the assessment was completed by an LPN and below that signature were the signatures and credentials of an RN.

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On / / at approximately 5 PM, the DON stated she was not aware that an LPN could not conduct assessments, even if reviewed and co-signed by an RN.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Bethesda On Turkey Creek
2800 Fordham Road, Ne
Palm Bay, FL 32905

RE: Relicensure w/LNS

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by representative(s) 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 surveyor(s). Should you have any questions please call Lorraine Henry at -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

XG90

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

Henry, Lorraine

From: CAU
Sent: Thursday, , 2015 8:34 AM
To: Henry, Lorraine
Cc: DeCanio, Theresa
Subject: FW: ALERT 7 15 DAY REPORT

Please review and let me know if you would like this opened for supervision. It looks like the staff did everything appropriately after the incident.

Thank you

Jeanine Morthier - **REGISTERED NURSING CONSULTANT**

Bldg. 2, 304 - HQA FIELD OPERATIONS
2727 MAHAN DRIVE TALLAHASSEE, FL 32308
850-412-4511 (Office) - (Fax)
cau@ahca.myflorida.com

From: Francis, Hazel
Sent: Wednesday, , 2015 1:53 PM
To: CAU
Subject: ALERT 7 15 DAY REPORT

FYI.

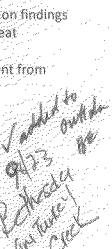
The following incident information is being sent to you as an ALERT. If you investigate this incident, please send Hazel Francis the EVENT ID. Thank you.

Report Number: 401484 Incident Number: 59529

Name of facility: BETHESDA ON TURKEY CREEK

After speaking with Margaret, I added some questions but the report had been updated (info added) before I added questions in the system.

1. In the analysis please provide a clear and complete explanation of the cause(s) of the incident based on findings from the facility's interviews and investigation conducted on this incident. This section should not simply repeat verbatim what has already appeared in another section of the report.
2. Please explain the corrective/proactive action(s) taken to prevent this type or a similar type of incident from reoccurring to this or other residents.
3. What are the medical and mental health history and diagnoses of the resident?
4. Please clarify: "Apparent self-inflicted ."
5. What time did staff last assess/see the resident and what state of being was the resident in?
6. Did the visitor/friend sign in to visit the resident? If so, what time did the friend sign in?
7. What is the outcome of the resident?
8. Were any diagnostic tests completed at the hospital? If so, list the tests along with the results.



9. "HE HAD A GAPING /LACERATION ON HIS UPPER INNER RIGHT ARM." Please elaborate.
10. Was the PCP/family notified? If so, what orders did the PCP give?
11. Was law enforcement called? Please elaborate.
12. What care did the staff provide until arrived?
13. Doing a conversation with the administrator, it was said that the resident "self-inflicted his right ." "He cut open his ." What did the resident use to self-inflict his ?
14. Was the resident having ? If so, was a evaluation ordered? Was the PCP/family notified? If so, what plan of care was implemented?

On / / @ 0910 (Hazel Francis) spoke with Margaret Conti, administrator, r/t this report. Margaret stated the following:
"I used the word proactive because there is nothing that we could do in the future to prevent it since it was unavoidable because it was something that he had done to himself."
"When I spoke with the after I got there, all they would tell me is that they couldn't say what happen only that they gave care to the resident and what they saw. I guess they didn't want to be responsible for what went on."
"Well it was apparent that he self-inflicted himself because there was no one there with him when the staff got to him; although I still don't know what he used because we find nothing that he could've use to do it."
"He cut open his right . There was a gaping to his right . He had to have been the one who had done it because there was no one else there when they found him. His friends found him on the floor of the ."
In the 15 report, it is stated that the resident's friend, Mike, found him. During my conversation with Margaret, she stated "That is how his friends found him".
After speaking with Margaret r/t the analysis lacking detailed information and explaining that the corrective/proactive action couldn't be measured because the analysis is incomplete, she stated that she understood and will correct the report. I also asked her if law enforcement was called and she stated "No." I asked her if they could not find anything at the scene that indicated the resident self-inflicted his own , how did they know he did it? She couldn't answer the question. It is not known to me if the resident has a or mental health history. Nothing that she spoke about during our conversation indicated that the resident was having . It is not known to me if the resident was having issues with another resident.

Hazel M. Francis, BSN, RN
Registered Nurse Consultant

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