| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11910386** | **01/28/2016** |
| NAME OF PROVIDER OR SUPPLIER **CITY WALK ACTIVE LIVING** | STREET ADDRESS, CITY, STATE, ZIP CODE **534 DATURA STREET WEST PALM BEACH, FL 33401** | |

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

**0000 Initial Comments**

A complaint inspection (CCR #s 2015013382 and 2016000041) was conducted on 1/27/16-1/28/16. City Walk Active Living, with a Limited Nursing Services Component, had the following deficiencies identified at the time of the survey:

**0025 Resident Care - Supervision**

Based on observation, interview and record review, the facility failed to provide care and services appropriate to meet the needs of the residents. This was evidenced by the failure to promote physical and well-being to 6 of 7 sampled residents (Residents #1, #2, #4, #5, #6 and 7). Resident# 2 had physical limitations requiring environmental modifications for activities of daily living (ADL); Resident #1 was bed bound requiring total ADL care; Residents #4-7, required greater staff supervision to avoid fights and to receive ongoing care to meet their needs.

The findings include:

1. Review of Resident #2's medical record indicated the resident was initially admitted to the facility on / with medical diagnoses including , with behavior, , controlled , abnormal gait, knee pain, , , , sleep , history of ( ) and . The resident's documented weight was 349 pounds. Further review of the record indicated that the resident had a history of on , , , and from which he sustained injuries and required medical evaluation and treatment. Review of the facility's reports about the incident revealed interventions to include the need for a larger hospital bed with side rails and to educate the resident to call for assistance prior to his attempting to ambulate or get out of bed alone. On after a , Resident #2 was transferred for treatment and then moved to a skilled nursing facility for rehabilitation, he was readmitted to the assisted living facility (ALF) on / . Review of the current Resident Health Assessment form dated on / indicated Resident # 2 was alert and oriented, ambulated with a walker and required physical ( ) along with precautions. Further review of the form indicated Resident #2 required staff supervision with ambulation, self-care and toileting and assistance with bathing, dressing and transfers.

In an interview with Resident #2 on / at 2 PM, the resident was observed sitting in his wheelchair in the living , on the 2nd floor memory care west unit. He stated that he had returned from a rehabilitation facility after receiving treatment for in both his legs. He wheeled himself back to his stated that he had chosen to sleep in his wheelchair since he had only a "single bed." He stated, he was fearful to sleep in the bed because he was a large man and was unable

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to safely turn side to side without falling off the bed. He stated,while he was in the skilled nursing facility, he had been provided a much larger bed. He stated, he had a history of and had sustained injuries attempting to move in the single bed. He stated, he required staff assistance to get to the that the limited space to facilitate his transfer from wheelchair to the toilet. He stated, he would stand from the wheelchair and pivot himself into the small grabbing the vanity sink cabinet for support. He stated, the toilet height was to low and he was afraid of falling. He stated, he required the caregivers to assist him to the toilet, but even after yelling out for assistance, nobody came. He stated, he wore a diaper and soiled himself because he could not get to the time. Resident #2's lower extremities were observed to be edematous and reddened. The resident stated, they were not painful but caused him difficulty with ambulation. He stated, he had been evaluated by since his return back to the ALF. He stated, he was unable to use his rolling walker due to the "worn" tennis balls on the tips of the rolling walker which caught on the unit's flooring. As a result, he stated he was afraid he would , and was only using his wheelchair. He stated, he was able to ambulate short distances and hoped his strength would improve.

In an observation of Resident #2 on / at 8:00 PM, he was observed sitting in his wheelchair in his darkened . When questioned why he was not lying in bed with his feet elevated, he stated, he did not want to get into bed, because he was afraid to off the bed into a " black hole." He stated, he would rather sleep in his wheelchair, even though he was uncomfortable. He stated the building had no call bell system so he was forced to yell out for assistance. The resident stated, on readmission he had requested a transfer to another company owned assisted living facility. He stated, he had spoken with the acting administrator and transfer plans for , 2016 were being discussed.

Record review of the initial assessment dated on / indicated that Resident #2 had complaints of generalized , history of frequent , loss of balance, tingling in lower extremities, lack of muscle coordination, limited ambulation ability, limited endurance and the fear of falling. Resident #2's legs were assessed to have , poor muscle tone, poor coordination, decreased sensation in both legs, gait endurance was poor with complaint of pain in legs at a score. The note indicated Resident #2's chief safety hazard as the , which was small with limited mobility. The resident's functional assessment indicated he had an unsteady gait pattern with staggering and swaying. He required for a distance of 10 feet with a rolling walker and required assistance with transfers with rolling walker for toileting. The assessment indicated a Tinetti Gait and Balance score of , which indicated a score less than 19 as a "high risk for ....." The assessment further indicated the resident had a fair rehabilitation potential.

In an interview with the facility's Acting Administrator and a consultant administrator from a corporate sister assisted living facility (ALF) on / at 8:15 PM, the Acting Administrator stated, Resident #2 was transferred from the skilled rehabilitation facility . The Acting Administrator stated, he

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had personally gone to the skilled nursing facility to discuss the resident's discharge. He stated, he was making plans to transfer the resident on 1, 2016 to another sister ALF, which had ground floor rooms, larger hallways, larger bathroom accommodations and availability of a larger bed. After surveyor intervention and questioning if the resident's care needs were being met upon his readmission on /, the Acting Administrator began to interview Resident #2 about his care and safety issues and offered to provide the resident a larger bed. Resident #2 stated, he would prefer to get a larger bed and then be transferred to the ALF as planned. On / at 9:20 PM, the Acting Administrator informed the surveyor that the resident had been transferred to the sister ALF. He stated, prior to the Resident #2's returns to the ALF, he was aware of the resident's past history and requirement for a larger bed. Furthermore, he stated, he was aware of the facility's environmental limitations, , toilet height, and had not made any successful attempts to provide alternative solutions to the resident upon his readmission to the building.

2. Review of Resident #1's medical record indicated that the resident had diagnoses including , , , and . Review of Resident #1's current Resident Health Assessment 1823 AHCA form dated on indicated the resident was "in bed mostly", had episodes of agitation/ combative behaviors and required hospice services. Further review of the form indicated that the resident was dependent for all activities of daily living (ADL) care, including being fed a pureed diet by staff.

Review of the hospice initial assessment for Resident #1 dated on / indicated that the resident had declined over the past the 3-6 months. He had been ambulatory with a rolling walker until 2015 and had a history of numerous . The assessment indicated that Resident # 1 had decreased mobility, increased , was bedbound, he was pocketing food and was placed on a pureed diet with staff feeding him since 2015. Further review indicated the resident responds with yes/ no answers, and was disoriented with skill. The resident was documented as withdrawn and sleeping hours a day. The assessment indicated Resident #1 required total ADL care by facility staff. Review of a nursing assessment dated on indicated that Resident #1 was , bed bound requiring total ADL care and required to be turned and repositioned in bed every 2 hours and as needed to prevent .

Review of Resident #1's hospice initial plan of care dated on indicated a plan of care to include areas for psychosocial care, to provide emotional support and active listening, and to provide total ADL care. The plan indicated that the facility staff should monitor skin integrity for breakdown, provide emotional support and stimuli, and to assist to manage feelings of and provide support/ comfort for feelings of loneliness.

Review of a hospice nursing assessment dated on / indicated that Resident #1 required total

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care and staff interventions were to include getting the resident out of bed to a high back wheelchair as tolerated. Review of the social worker notes dated on 1/14/2016 indicated that the resident was more alert and able to answer questions but frustrated with his memory loss. Resident #1 was documented to have enjoyed visiting with the social worker.

In an observation of Resident #1 on 1/ at 3 PM, the door to the resident's closed. Inside the , Resident #1 was observed lying in bed, on his back, with side rails raised on each side of his bed. The blinds were drawn and the darkened. The resident was alert to his name only.

In an additional observation on 1/ at 6:30 PM, the door to Resident #1's closed. The resident was observed asleep, lying in bed, on his back.

In an observation on 1/ at 10:30AM, the resident's was closed, Resident #1 was observed in bed, lying on his back. A sign was posted above the residents bed which documented, "provide juice every 2 hours to prevent ." Resident #1 was awake and alert to his name. He smiled and responded to simple questions with yes/no answers. The observed to have no television, no radio and no personal items.

In an interview with caregivers # C and #D on 1/ at 10:35 AM, they stated, Resident #1 was very weak and unable to feed himself. They stated, they fed the resident his meals in his . When questioned if Resident #1 gets out of bed to his wheelchair, they stated, Resident #1 could not assist with transfers and was very heavy which required 3-4 staff to lift the resident to the chair. They stated, often they would request the male housekeeping staff to assist them with the resident's transfer. The caregivers stated that Resident #1 did not get out of bed that often as a result. They stated, he did not attend facility's activity programs.

On 1/ at 11:17 AM, Staff #C stated, she worked alone on the memory care unit on 1/ . She further stated, Resident #1 was left in his wheelchair from 6 AM-1PM. He was too heavy for Staff #C and the other Nursing Assistants on duty to lift. The resident stayed there for the whole shift and finally Staff # C and the other Nursing Assistant dragged Resident #1 out of the chair and into his bed because no one came to help them and they were worried that the resident needed to lie down.

In an observation on 1/ at 11:45 AM, on the memory care unit where Resident #1 lived, two caregivers were observed preparing the lunch meal by placing the prepared food trays into warming units. When questioned by the surveyor about Resident #1's meal, the care givers were observed to look over the food carts and found a plate with pureed food, covered with plastic wrap, which had been placed under a large metal bowl of ice. The surveyor questioned the identification of the pureed food and both care givers stated they did not know. Care giver #D then began to uncover the plate and was

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preparing to serve the plate of food to the resident. With intervention by the surveyor, she stopped unwrapping the plate and stated that she didn't know what food was on the plate or if the food should be heated or cooled. The caregiver stated she would return to the kitchen to determine the identity of the food items. Upon her return 10 minutes later, Caregiver #D was observed with a new plate covered with plastic wrap and she stated, the food items were pureed fish and mashed potatoes blended and applesauce. She stated, the fish/mashed potatoes mixture was hot.

In an observation on / at 12:00 PM the resident's was closed. Resident #1 was observed lying on his back, asleep. At 12:10 PM, Caregiver #D entered the resident's awakened him. The care giver informed Resident #1 that it was time for his lunch and she raised the head of bed and repositioned the resident. The resident was alert and was able to answer simple yes/no questions from the caregiver. Care giver #D began to feed the resident and he expressed that the food was good. Resident #1 was observed to swallow after each bite but had several episodes of coughing while eating. The care giver provided thickened juice and Resident #1 was not observed to make any attempt to raise his hands during his coughing episodes or assist the caregiver during his meal.

Record review of the facility progress notes for Resident #1 after admission to the hospice, indicated no documentation that the hospice care plan was followed for the resident to be turned and positioned every 2 hours or transferred out of bed to his wheelchair daily as tolerated. Additionally, there was no documentation that Resident#1 had been offered or participated in any social activity within the facility. The resident was bed bound, unable to leave his the caregiver assistance and therefore had limited social interactions except with select care givers.

3. On / at 3:05 pm, Staff #E stated, a few months back, she and the assistant administrator broke up a fight. A man and woman were arguing and the woman threw hot coffee on the man. The man on whom the coffee was thrown got very verbally at the woman, and another man got involved. A fistfight ensued. The man who got the hot coffee thrown on him was discharged (Resident #4). Resident #5, the other man who was involved, still lives at the facility, as does the woman, Resident #6.

A review of the records of Residents #4, #5 and #6 revealed no documentation of the incident. A review of the facility's report log revealed, on , Resident #7 forcibly grabbed a Certified Nursing Assistant (CNA) and another resident. A review of the resident record for Resident #7 revealed no documentation of this incident. No internal documentation was found indicating that a preventive action against repeated occurrences was put in place.

Class III

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**0030 Resident Care - Rights & Facility Procedures**

Based on observation and interview, the facility failed to provide a safe and sanitary living environment with adequate supplies for resident care to honor the rights of the facility's residents.

The findings include:

An observation tour was conducted during the survey from / - / . Observations and interviews were conducted throughout this tour.

Observations made during the tour are:

1. In an observation on / at 2 PM while the surveyors were waiting in the hallway for a work space to conduct the survey, a 2-inch brown bug crawled from under an adjacent door into the hallway. The Acting Administrator present at this time stated, "the bugs are coming inside due to the excessive rainfall outside."

2. During an interview with a resident on / at 7:30 PM who lives on the 2nd floor memory care unit west side, he informed the surveyor, there was a 1-1/2-inch brown bug crawling around the surveyor's feet. He stated, there were bugs in his after the exterminated. The resident's also stated, he observed bugs crawling inside the treatments.

In an interview with the Acting Administrator on / at 8:00 PM, he was informed of the resident's concerns about insects. He stated, the facility has a contract with an exterminator who treats the entire building monthly and as needed. He stated the facility was an older building therefore it was difficult to control insects entering.

3. During an observation of medication administration for Resident #3 by the hospice nurse on / at 4 PM, the hospice nurse was observed to utilize hand sanitizer before and after administering medications to the resident. Resident #3 was on 24-hour nursing monitoring care for recent decline and required total care. When the nurse was questioned by the surveyor why she did not use the resident to wash her hands before preparing medications and after treatments, the hospice nurse stated that there was no soap in the resident . She stated, she had to leave the resident's go down the hallway to a wash her hands with soap.

In an interview with care giver #A on / at 8:30 PM, she stated, residents provide their own soap, if they have a their . She stated, when she needed to wash her hands, she would go to the "shower " which had a soap dispenser on the wall. When questioned if she had been trained

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on control principles, she stated, she had completed the training. She stated, she routinely removed her gloves after caring for a resident, then walked out of the resident room, down the hallway to the shower room, to wash her hands. She stated, she would need to touch the door handle to exit the resident acknowledged that she should be washing her hands immediately after completing resident care.

4. On / at 10:33 AM, Staff #J stated, that equipment is missing or does not work. Sometimes there are no washcloths to wash the residents. Staff J also stated, sometimes there is no soap or body wash, and that sometimes there are no clean sheets to put on the beds. There are times when the employees don't have any gloves and she has to bring gloves from home.

5. On / at 11:00 AM, observed feces on the floor and on the outside of the toilet on memory care east, rear dining area.

Class III

**0079 Staffing Standards - Levels**

Based on observation, record review, and interview, the facility failed to provide enough qualified staff to provide care that met the Activities of Daily Living needs of 2 of 2 sampled residents (Resident #1 and #2).

The findings are:

a) Review of the facility census list provided at 2:15 PM on /, indicated that there was a census of 160 residents in the facility, of which 40 residents reside in the two memory care units, Sunshine West and Sunshine East, located on the 2nd floor. Review of the facility staffing hours for the week of / to / indicated that on /, /, /, /, there were 2 direct care staff members scheduled to work the daytime shifts and evening shifts on each of the 2 memory care units (East and West wing). Further review of the staffing schedule indicated that on /, there were 2 direct care staff assigned to the East memory care unit and only 1 direct care staff assigned for the West memory care unit. Further review of the staffing schedule for / indicated one other "universal" direct care staff member was assigned to care for the remaining residents residing on the 3rd and 4th floor.

In an interview with the Acting Administrator on / at 4:00 PM, he stated, each memory care unit is staffed with 2 direct care staff on the day and evening shifts and one direct care staff is assigned on the night shift. He stated that the combined 2 memory care units are staffed with one medication technician, during the day and evening shift, whose main responsibility is to pass medications to the

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residents. When he was questioned about a 2nd caregiver for the west memory care unit on 1/27/2016 he stated that there was no caregiver assigned due to short staffing that evening and he was unaware of the situation until surveyor questioning.

b. Review of Resident #2's medical record indicated the resident was initially admitted to the facility on / with medical diagnoses including with behavior, controlled , abnormal gait, knee pain, , sleep , history and . Further review of the record indicated that Resident #2 had a history of on , , , and from which he had sustained injuries and required medical evaluation and treatment. Review of the facility incident reports for these revealed included interventions to educate the resident to call for assistance prior to his attempting to ambulate or get out of bed alone. After treatment for a on , Resident #2 was transferred to a skilled nursing facility for rehabilitation and was readmitted to the facility on /. Review of the current Resident Health Assessment form dated on / indicated Resident # 2 was alert and oriented, ambulated with a walker and required precautions. Further review of the form indicated Resident #2 required staff supervision with ambulation, self- care and toileting and assistance with bathing, dressing and transfers.

In an interview with Resident #2 on / at 2 PM, he stated, he had returned from a rehabilitation facility a few days ago, after receiving treatment for in both his legs. He stated, he was fearful to sleep in his single bed because he had a history of and had sustained injuries attempting to move in the bed. He stated, he required staff assistance to get to the the limited space to facilitate his transfer from wheelchair to the toilet. Resident #2 stated, he would stand from the wheelchair and pivot himself into the small grabbing the vanity sink cabinet for support. He stated, the toilet height was low and he was afraid of falling. He stated, he required his caregivers to assist him to the toilet but even after yelling out for their assistance, nobody came. He stated, he wore a diaper and soiled himself because he could not get to the time. He stated, there was no call bell system to request caregiver assistance.

Review of Resident #1's medical record indicated that the resident had medical diagnoses including , , and . Review of Resident #1's current Resident Health Assessment 1823 AHCA form dated on indicated the resident was "in bed mostly", had episodes of agitation/combative behaviors and required hospice services. Further review of the form indicated that Resident #1 was dependent for all activities of daily living (ADL) care, including being fed a pureed diet by staff.

Review of the hospice initial assessment for Resident #1 dated on / / indicated that the resident had declined over the past the 3-6 months. He had been ambulatory with a rolling walker until

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2015 and had a history of numerous . The assessment indicated that Resident # 1 had decreased mobility, increased , was bedbound, he was pocketing food and was placed on a pureed diet with staff feeding him since 2015. Further review indicated the resident responds with yes/ no answers, and was disoriented with skill. The resident was documented as withdrawn and sleeping hours a day. The assessment indicated Resident #1 required total ADL care by facility staff. Review of a nursing assessment dated on / indicated that Resident #1 was , bed bound requiring total ADL care and required to be turned and repositioned in bed every 2 hours and as needed to prevent .

Review of Resident #1's hospice initial plan of care dated on indicated a plan of care to include areas for psychosocial care, to provide emotional support and active listening, and to provide total ADL care. The plan indicated that the facility staff should monitor skin integrity for breakdown, provide emotional support and stimuli, and to assist to manage feelings of and provide support/ comfort for feelings of loneliness.

Review of a hospice nursing assessment dated on / indicated that Resident #1 required total care and staff interventions were to include getting the resident out of bed to a high back wheelchair as tolerated. Review of the social worker notes dated on / indicated that the resident was more alert and able to answer questions but frustrated with his memory loss. Resident #1 was documented to have enjoyed visiting with the social worker.

In an observation of Resident #1 on / at 3 PM, the door to the resident's closed. Inside the , Resident #1 was observed lying in bed, on his back, with side rails raised on each side of his bed. The blinds were drawn and the darkened. The resident was alert to his name only.

In an additional observation on / at 6:30 PM, the door to Resident #1's closed. The resident was observed asleep, lying in bed, on his back.

In an observation on / at 10:30AM, the resident's was closed, Resident #1 was observed in bed, lying on his back. A sign was posted above the residents bed which documented, "provide juice every 2 hours to prevent ." Resident #1 was awake and alert to his name. He smiled and responded to simple questions with yes/no answers. The observed to have no television, no radio and no personal items.

In an interview with caregivers # C and #D on / at 10:35 AM, they stated, Resident #1 was very weak and unable to feed himself. They stated, they fed the resident his meals in his . When questioned if Resident #1 gets out of bed to his wheelchair, they stated, Resident #1 could not assist with transfers and was very heavy which required 3-4 staff to lift the resident to the chair. They stated,

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often they would request the male housekeeping staff to assist them with the resident's transfer. The caregivers stated that Resident #1 did not get out of bed that often as a result. They stated, he did not attend facility's activity programs.

Record review of Resident #1's facility progress notes from hospice admission to present indicated no documentation that the care plan was followed for the resident to be turned and positioned every 2 hours or transferred out of bed to his wheelchair daily as tolerated. Additionally, there was no documentation that Resident #1 had been offered or participated in any social activity within the facility. He was bed bound, unable to leave his caregiver assistance and therefore had limited social interaction except with select care givers.

c) On I/ at 11:17 AM, Staff #C stated, she worked alone on the memory care unit on I/ . She further stated, Resident #1 was left in his wheelchair from 6 AM-1PM. He was too heavy for Staff #C and the other Nursing Assistants on duty to lift. The resident stayed there for the whole shift and finally Staff # C and the other Nursing Assistant dragged Resident #1 out of the chair and into his bed because no one came to help them and they were worried that the resident needed to lie down.

On I/ at 7:48 pm, Staff #H stated that occasionally on the 3rd & 4th floor if the staff goes home sick, it is understaffed. She further stated that this had happened within the previous week when one of the staff went home sick at around 3 AM.

A review of payroll and time clock records revealed that there were only three staff on duty between 2:30 am and 6:00 am on Tuesday, I/ .

On I/ at 12:22 pm, Staff #I stated that she left work at 2:30 AM on I/ because she was ill. Three people were on duty in the facility when she left I/ .

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
City Walk Active Living
534 Datura Street
West Palm Beach, FL 33401

**RE: CCR #2015013382 and #2016000041**

Dear Administrator:

This letter reports the findings of a complaint state licensure survey that was conducted on 27-28, 2016 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 , 2016.** 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/dso
Enclosure
XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com