STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910386	06/22/2016
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
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0000 Initial Comments

On 06/15/16 through 06/16/16 and 6/22/16 a complaint survey (CCR #2016004973) was conducted at City Walk Active Living, license #7617, located at 534 Datura St, West Palm Beach, FL. Deficiencies were identified during the survey.

0025 Resident Care - Supervision

Based on interview and record review, the facility failed to provide care and services appropriate to meet the needs of the resident who had verbal limitations and experienced changes in condition. This was evidenced by the failure to notify the resident's family and health care provider of the changes and to receive direction for care and failure to document the changes for 1 of 18 sampled residents' records reviewed (Resident #17). The facility failed to ensure that 1 out of 18 sampled residents (Resident #8) was safe and failed to provide supervision after the resident had multiple or .

The findings include:
a) Review of Resident #17 ' s medical record indicated that the resident was admitted from another facility on . Review of the resident health assessment form dated on / indicated that the resident had medical diagnoses of , aphasia, , , and . Further review of the assessment indicated the resident was alert but had and a history of . Review of the assessment indicated that Resident #17 ambulated with a walker and had limitations in both shoulders. Further review of the form indicated the resident was independent for ambulation, self- care, toileting and transfers and required staff assistance with bathing and dressing. Review of the form indicated that the resident required her family ' s assistance with handling personal and financial affairs.
Review of a , progress note dated on indicated that Resident #17 was living on the memory care wing of the facility and had a diagnosis of . The resident was oriented to self and was stable while being treated with daily. The note indicated that the resident's movement was slow and her judgement was fair.
In an observation on at 7:15 AM on the east memory care wing, the surveyor observed several funeral home personnel transporting a resident. Upon questioning of the memory care staff at that time, they stated that Resident #17 had that morning at 3:20AM.
In an interview with Resident #17 ' s family member on at 8:30 AM, he stated that the resident had lived at the facility since 2015 and that he and his brother were her power of attorneys. He stated that Resident #17 had a history of "multiple (6) , 3 major, "which had severely her ability to speak; she was only able to answer, "si or no." He stated Resident #17 ' s primary language was Spanish and that her ability to write had not been affected. He stated that Resident #17 was able to ambulate very slowly and awkwardly with the use of a rolling walker and she had no

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that he was aware of. He stated that on Saturday, 6/11/2016, he had taken the resident out of the facility, to spend time at his home with her extended family. He stated that she appeared to be in "good spirits" and had a good time, eating and watching movies and that she returned to the facility at around 8pm that night. He stated that he had noticed that both of Resident #17 ' s feet were during the visit. He stated that he phoned Resident #17 on Monday, and he informed her that he had made a physician appointment to evaluate her feet. The family member stated that the resident had numerous medical conditions, but she had been stable on her medications and had not made any complaints to him. He stated that he received numerous calls to his cell phone, starting around 4:20 AM on but he had been asleep. He stated that when he awakened at 5:30AM, he noticed the messages and immediately called the facility. He stated that he was informed by the facility staff member that Resident #17 had that morning and he was overcome with grief. He stated that he was informed that Resident #17 had been found at around 11:00PM on , sitting on the floor in her a possible and the staff had lifted her and transferred her to a chair. He stated that he was informed that the resident indicated that she was "ok," but then she was observed to reach up to her temple and said she had a "little mark on the side of her head." He stated that he had not received any call from the facility prior to her and he would be the emergency contact to make health care decisions for his mother. He stated that he was told that the staff checked the resident every 30 minutes and they had observed her at around 3:00AM to be " and coughing." He stated that he was informed that Resident #17 became short of breath, losing and the staff began . 911 was called and Resident #17 was pronounced at 3:20AM. He stated that he came to the facility immediately after he spoke to the facility to view the resident. He stated that he had not been notified that Resident #17 was found on the floor or that she began to . He stated that he was the responsible person to make any health care decisions including transfer to a higher level of care for evaluation.

Review of the facility electronic progress notes for / - / , indicated no documentation of the 30- minute observation checks of the resident's condition or care interventions that staff had implemented.

Review of a facility incident report completed by Caregiver #E on at 11:30PM indicated the caregiver heard a cry for help coming from Resident #17 ' s . The caregiver wrote that she entered the resident's find the resident sitting on the floor with the walker beside her. The caregiver documents she asked Resident #17, "if she was in pain and resident #17 "stated that her stomach hurt a little." The report further indicated that Resident #17 was smiling and "talking good." The care giver wrote that she questioned the resident if she wanted to go to the hospital and the resident began to cry, stating, "no." The report indicated that Caregiver #E changed the resident's brief and checked on the resident every 30 minutes with no concerns observed. Review of the incident report completed by another Caregiver # H on at 11:30PM indicated that she was called to the resident's Caregiver #E and observed Resident #17 sitting on the floor with her walker beside her. The report indicated the resident was alert, smiling and responding to the caregivers that she was "fine." When

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asked by the caregivers if she wanted to go the hospital the resident said "No, NO" and began to cry. The report indicated that the caregivers assisted the resident to bed and observed for or injury and no injury was noted. The report indicated the caregivers changed the resident's briefs and the resident was monitored every 30 minutes.
In an interview with Caregiver #E on at 10AM, she stated that she had cared for Resident #17 often and that the resident was independent to ambulate with the walker to the toilet herself. The caregiver stated that she was unaware if the resident had ever sustained a or was considered a risk. She stated that the resident was alert but unable to verbalize words, only yes or no answers. She stated that around 11:30PM on , she heard a scream coming from Resident #17 ' s . She stated that she entered the find Resident #17 in a sitting position on the floor. She stated she asked the resident if she was ok and the resident stated, "Si" or yes. The caregiver stated that she asked Resident #17 if she needed to go to the hospital and she stated, "No, No." Caregiver #E stated that she asked the resident, if she had pain anywhere, and the resident "pointed to her stomach area." Caregiver #E stated that along with another aide, Resident #17 ' s entire body was observed for or redness and no marks were found. She stated that she notified her supervisor/ Caregiver #F of the incident and was instructed to monitor Resident #17 every 30 minutes for any changes. The caregiver stated that she did not notify the physician or family of the incident. The caregiver stated that around 2AM, she entered the resident ' s conduct the check and asked the resident if she was alright. Resident #17 responded to her question of "are you wet and need to be changed?" with a yes/ si, answer. Caregiver #E stated that sometime before 3AM, the resident began to , thick yellowish vomitus, so she turned Resident #17 on her side, wiped her mouth, cleaned her up and changed her soiled top. The caregiver stated she went to call the supervisor to inform her about Resident #17 ' s condition. Caregiver #E stated that Caregiver #G was sent to assist her with the resident. The resident had responded to her care by nodding her head, but when Caregiver #G arrived the resident became unresponsive. Caregiver #G turned the resident on her back, checked for a heartbeat and began ( ). Caregiver #E stated that 911 was called by the supervisor and they arrived within minutes to take over from Caregiver #G. Caregiver #E stated that the Emergency Medical Service ( ) personnel were unable to revive the resident and called her at 3:20AM.
In an interview with Caregiver #H on at 2:00PM, she stated that she was unaware of any history for Resident #17. She stated that she and Caregiver #E entered the resident's found the resident on the floor on / . She stated that she didn't speak Spanish, but she asked the resident if she hurt anywhere and the resident "pointed to her stomach." Caregiver #H stated that she asked the resident if she had hit her head on the floor and the resident responded, "no." Caregiver #H stated that she assisted the resident to bed and at approximately 12-12:30AM, she entered the resident's check her. She stated that she changed the resident's brief and instructed her not to get up by herself but to call for assistance. Caregiver #H stated that at approximately 2:30AM, she assisted Caregiver #E with the resident who was . She stated that she left to locate the supervisor and was instructed to remain on the west memory care unit. Caregiver #H stated that when

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she left the east memory care unit, the resident was responsive and . She stated that she was not present when the resident became unresponsive.
Review of the incident report completed by Caregiver #E on at 3 AM indicated that at approximately 3 AM, while performing rounds Resident #17 started to . The caregiver notified her supervisor and they cleaned the resident up. The report indicated that the resident started to have "," so was started. The report indicated that the paramedics arrived and took over caring for the resident and that the resident at 3:20AM. The report indicated the staff notified the Administrator, case manager, and family. Review of the incident report completed by the Caregiver #G on at 3 AM, indicated that she was called for assistance by Caregiver #E and both asked the resident if she wanted to go to the hospital. The resident was alert and responded, "no." The resident became unresponsive and was initiated by caregiver #G.
In an interview with Caregiver #G on / at 2:40PM, she stated that she was assigned to the west memory care unit on - 10pm-6am shift. She stated that around 2 am Caregiver #E informed her that Resident #17 was and she had provided the resident with fluids. She stated that her supervisor Caregiver #F had instructed her to go to the east memory care unit to assist with Resident #17. Caregiver #G stated that when she entered the , she observed Resident#17 to be lying on her side in bed, and she was not . She stated that the resident was initially responsive nodding her head but became unresponsive. The caregiver turned the resident on her back and felt for a pulse and began . She stated that she yelled for supervisor Caregiver #F to call 911. She stated the arrived around 3:08 AM and took over caring for Resident #17. She stated that around 3:20 AM, the informed her that the resident has . She stated that she informed the front desk receptionist to notify the Executive Director, Administrator and Assistant Administrator.
In an interview with Supervisor/ Caregiver #F on at 2:05pm, she stated that she was not a licensed nurse but an unlicensed caregiver, assigned as the night supervisor. She stated that she was unaware if Resident #17 had a history. She stated that on at around 11:30PM, she was notified by Caregiver #E that Resident #17 was found on the floor in her . The supervisor observed the resident sitting on the floor and when asked if she was alright, the resident responded, "si." The Supervisor stated that she and Caregiver #E checked the resident's entire body and found no redness or . The supervisor stated that it was her opinion that the resident slid to the floor and did not . She stated that she did not notify the physician of her observations. The Supervisor stated that around 2 AM, Caregiver #E informed her that that Resident #17 had started to . The supervisor stated that she instructed Caregiver #G to go assist Caregiver #E with the resident. The Supervisor stated that she started to gather the medical paperwork to transfer Resident#17 out to the hospital for evaluation, but could not recall the exact time. She stated that she observed Caregiver #G walking into the resident's then heard her yell to "call 911." The Supervisor stated that 911 was called and personnel arrived almost immediately and took over procedure. The supervisor stated that personnel informed her that the resident .
Review of Emergency Medical Services ( ) report dated on / indicated that the 911 call was

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received by the West Palm Beach Fire Rescue at 3:10AM. The report indicated that the personnel arrived at the facility at 3:15AM and responded to an / unresponsive resident by providing advanced life support.
Review of the timeframe from activation and the times/observations expressed by multiple caregivers during their interviews indicated that the resident had been experiencing symptoms of for a minimum of 25-30 minutes prior to activation. The resident's family and physician were not notified of the resident's symptoms during this time period.
In an interview with Resident #17's physician on at 9:05 AM, he stated that he had not examined the resident for quite a while but recalled that the resident had multiple health conditions along with issues. He stated that Resident #17 was aphasic and had limited verbal and ability due to multiple . He stated that he was notified around 3 AM of the resident's by a message left on his phone. When questioned if he had been notified that Resident #17 was found on the floor, complained of stomach pain or had been experiencing , he stated that he had not been called for consultation.
Review of the facility's policy on "Resident " dated / indicated that the procedure included to assess the situation and do not move the resident but call 911 if emergency assistance is needed, for example, if the resident is complaining of pain. Review of the policy indicated to provide comfort measures to the resident and if the resident can stand with minimal assistance, move the resident to an area where the resident can sit. The policy indicated that the shift supervisor is to be notified and the caregiver who reported the incident is to complete an incident report and document in the resident medical record. Review of the facility electronic medical record indicated no documentation of the incident or events that occurred on / .
In an interview with the Administrator on at 2:30PM, he stated that Resident #17 had no prior history and ambulated independently with a rolling walker due to history of multiple . He stated that the resident was alert but lived on the memory care unit for monitoring. He stated that that since the caregivers did not witness Resident #17 to the floor on / , the resident "did not sustain a , that she may have just sat herself on the floor." He stated that the caregivers asked Resident #17, if she was injured and she responded with "no" answers. He stated that the caregivers did not contact the family or physician after the resident was found on the floor or when the resident began to . When questioned by the surveyor why the family had not been informed that the resident was observed on the floor even with no prior history, he stated that the resident had not or been injured. He stated that no licensed nurse was on duty to assess the residents at night. He stated that the staff followed the decision of the resident, not to be transferred to the hospital for evaluation since she was not injured.
b) On / at 10:38 AM, a record review was conducted of the resident file for Resident #8. Handwritten notes in the file ended on . An electronic note printed off by request dated stated Resident #8 had a in the dining refused to go to the hospital with emergency medical services ( ). The resident had a second on and was

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transported to the hospital. Resident #8 was seen by the Advanced Registered Nurse Practitioner (ARNP) on 04/28/2016 and labs were ordered. On Resident #8 was again seen by the ARNP and had a medication change. An electronic note dated read, " 10:00 AM Resident was transported to the {name of the hospital} due to a . Emergency contact was notified. Resident was admitted to {name of the hospital} . " The note was entered by Staff C. Resident #8 was admitted to the hospital. Discharge paperwork from the hospital was dated . An electronic note dated read, "10:00 am Resident returned home from {name of the hospital} . Discharge diagnosis: . Family member was made aware of his return. " An electronic note dated / read " 11a WPB Police came to report Resident #8 had a at Publix. He was transported to {name of the hospital} . They said he had a gash on his head that would probably need stitches. Family was notified and administration was notified."

On / at 10:38 AM, a continued record review was conducted of the Agency's Health Assessment form 1823 (1823) for Resident #8. The 1823 was dated . Resident #8 had listed under medical history and diagnosis " Chronic Obstrctive ( ), , , hx surgery, hx of tobacco use, . " Under the heading "Precautions" was written "Universal." Under the heading " Ability to perform self-care tasks "was" shopping," and Resident #8 was listed as requiring assistance.

A continued record review on / at 10:38 AM was conducted of a letter in Resident #8 ' s resident file from his personal doctor. It was dated , 2015 and read, " Please be advised that " Resident #8 " is currently under my medical care at an Assisted Living Facility where he is homebound due to chronic mental illness and advanced stage . " Resident #8 " was last seen on , , 2015 following a hospitalization related to a ."

On at 12:21 PM, an interview was conducted with Resident #8. Resident #8 was using a cane to assist with ambulation. Resident #8 stated he walks to Publix on his own.

On at 2:35 PM, an interview was conducted with the Executive Director. The Executive Director stated their policy states, a resident is not a risk until they have three times, therefore, they did not need a new 1823 for Resident #8. The Executive Director stated, Resident #8 had not been having , and "this was very recent." She further stated Resident #8 is able to walk to Publix on his own and sign himself in and out. The Executive Director stated, Resident #8 is not assisted while shopping at Publix.

A record review on at 3:09 PM was conducted of the incident report dated . The incident report had an action plan for preventing a reoccurrence of , and stated " do hourly checks. " The incident report had been filled out by Staff O.

On / at 3:09 PM, an interview was conducted with Staff C. Staff C stated the incident report had been misfiled and had been up at the receptionist desk since it was filled out. Staff C stated they had checked on Resident #8 "more frequently, " but the checks were not documented. Staff C further stated they do not need to do the hourly checks any longer, as Resident #8 is no longer having .

On / at 3:20 PM, an interview was conducted with the Administrator. The Administrator stated,

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the directive to perform hourly checks was only meant to occur for a day, not ongoing. The Administrator stated they are not required to document that they performed the hourly checks. The resident returned from the hospital on and had a on / while out of the facility by himself, during the timeframe the Administrator stated they should be performing hourly checks.
On at 3:38 PM, an interview was conducted with Physician #2. Physician #2 stated Resident #8 had been -free for three years under his care. Physician #2 stated following multiple and a hospitalization for a , Resident #8 should have had a new 1823, and it should have identified him as a risk. Physician #2 stated Resident #8 should have had someone with him from the facility "especially leaving the facility" to go to Publix. He further stated, Resident #8's is " pretty advanced " and that he had documented that Resident #8 required assistance with shopping. Physician #2 stated, he " wouldn't feel safe allowing him to leave the facility on his own "due to the ."

Class II

0030 Resident Care - Rights & Facility Procedures

Based on record reviews, interviews and observation, the facility failed to provide a safe and decent living environment free of pests; specifically, an environment free of roaches and bed bugs, for 4 out of 4 floors toured. The facility failed to provide convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, for 4 out of 4 floors toured.

Findings include:

In a record review on / of a Department of Health inspection report dated , the report documented an inspection for bed bugs on in which bed bugs were found in . The report documented the Administrator was advised to treat the area 3 times by a pest control company by .

In an interview on at 8:07 AM with the Administrator, the Administrator stated he did not have a report from the Department of Health related to an inspection on .
In an interview on at 8:11 AM with Staff B, Staff B stated the facility had completed treatment for bed bugs in .
In a tour on at 2:30 PM observations were made of . Small black bugs were observed on the resident mattress and headboard, and a mold-like substance was observed on the air conditioning unit. Resident #1, who resided in , was observed to have bug bites on his chest, stomach, and back.
In an interview on / at 2:40 PM with Staff B, Staff B stated he has treated 3 other for bed bugs since the Department of Health inspected on .

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In an interview on 6/16/16 at 7:55 AM with the Executive Director, it was requested the Executive Director provide all of the pest control invoices related to treatment for bed bugs.
In a record review on of pest control invoices, the invoices detailed that the facility has treated 4 (338, 438, 445 and 314) for bed bugs since .
In an interview on / at 8:11 AM with the relative of Resident #1, the relative stated they spoke to assistant Administrator on . The relative stated the assistant Administrator told her the facility does not have bed bugs and the facility is not treating resident for bed bugs.
In a continued interview on at 8:11 AM with the relative of Resident #1, the relative stated Resident #1 was moved to a new facility which refused to accept Resident #1 ' s belongings based on the bed bug infestation.
In an interview on at 10:15 AM with Residents #15 and #16, the residents stated they have lived in their a while. The residents stated they have told the Administrator about the bed bugs. The residents stated the last treatment was on , and the treatment consisted of the housekeepers wiping down the mattresses.
In an interview on / at 12:21 PM with the Administrator, the Administrator stated the facility does not have a written policy regarding bed bugs. The Administrator stated the verbal policy is, "See something, say something."
In a tour of the facility on at 1:00 PM with the Department of Health and the Administrator, resident was observed. It was observed had a new mattress, head board, washed walls and air conditioning unit installed since the observation on / .
In a continued tour of the facility on / / at 1:00 PM with the Department of Health and the Administrator, it was observed 338, 316, 423 and 441 all had active bed bugs as identified by the Department of Health.
In a continued tour of the facility on / at 1:00 PM with the Department of Health and the Administrator, it was observed that the mattress in was covered in dried .
In an interview on at 1:30 PM with the Administrator, the Administrator stated he is not sure of how to handle the bed bugs since many of the residents hang out during the day with homeless citizens and bring the bed bugs back to the facility. When asked by the Department of Health Inspector about his policy on bed bugs, the Administrator stated, "We don't have a policy on dealing with the bed bugs coming into the facility."
On at 11:43 AM, an interview was conducted with Resident #23. Resident #23 stated she had bed bugs in her recent as two weeks ago. Resident #23 stated she saw three bed bugs, and the been treated.
On at 12:39 PM, an interview was conducted with Resident #24. Resident #24 stated he does not have a cell phone, but the facility has a phone on the opposite wing that he can use. He stated he is not allowed to take it back to his , and there is no place that is private that he can have a conversation. Resident #24 stated he must remain in the open and everyone can listen in on his conversation.

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In an interview on 06/15/2016 at 1:01 PM with Resident #25, Resident #25 stated his room has been treated for bed bugs five times in the past week. Resident #25 showed what appeared to be bed bugs on the floor, against the wall, and behind his nightstand.

On / at 1:40 PM, an interview was conducted with Resident #1. Resident #1 stated, "I hate living here." Resident #1 stated he has bed bugs in his they have been biting him. Resident #1 stated when he first moved in his window air conditioner unit didn't work, and they said they gave him one that works, but it doesn't. Resident #1 stated he is always hot and his 't cool down. Resident #1 stated he requested to move twice and was denied both times.

On at 1:40 PM, an interview was conducted with a relative of Resident #1. The relative of Resident #1 stated, Resident #1 moved in to the facility in . The relative stated when her resident #1 moved into the facility, the window air conditioning unit was not working. She stated she told the facility and they stated they replaced it. The relative said the air conditioner they said they replaced it with doesn't cool the . The relative stated the shower in Resident #1's 't work upon admission, and it was not fixed for almost five weeks. The relative stated the infested with bed bugs, and that Resident #1 has multiple bites on his stomach and his back. The relative moved furniture in Resident #1's small black bugs that appeared to be bed bugs were observed behind the bed and the nightstand, both and alive. The relative stated she has witnessed the Administrator being rude to the residents. She stated he will be pleasant in front of others, but she has personally witnessed him being very rude to residents. The relative of Resident #1 stated, " I entrusted my {family member} to their care and they allowed him to live in a with bed bugs, be bitten by bed bugs, have an air conditioner that didn't work, and a shower that didn't work for several weeks. That is unacceptable."

An observation on / at 11:30 AM was made of a large roach scurrying in and out of the elevator on the first floor in the lobby as the doors opened and closed.

On at 11:31 AM, an observation was made of Resident #36 as he attempted to exit the building from the hallway outside of the activity the covered courtyard. Resident #36 requires a wheelchair for ambulation. The button to open the door automatically for residents in wheelchairs was not working. Resident #36 attempted to open the door from his seated position and hold it open while pushing his wheelchair. Resident #36 was not able to exit, and after a few minutes another resident assisted.

On at 11:34 AM, an interview was conducted with Resident #36. Resident #36 stated the automatic door openers from the inside of the building and from the outside have been broken since Christmas. Resident #36 has stated he has asked when it would be fixed without response.

An interview on at 11:35 AM was conducted with Resident #32. Resident #32 stated she had bed bugs in her a very long time. Resident #32 stated she was afraid to lay down her head. Resident #32 stated, "it is a creepy feeling." Resident #32 stated she was upset because her be the one place in the facility where she feels safe. Resident #32 stated, she has to wait in a long line up to an hour for medications. Resident #32 stated, the people giving out medications "didn ' t

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wear gloves until the state showed up." Resident #32 stated, "they didn't close the door either " to the medication room when handing out medications. Resident #32 stated, she has enjoyed the change.
On at 11:45 AM, an interview was conducted with Resident #37. Resident #37 stated there were many roaches in the facility. Resident #37 stated, they spray a lot for roaches and bed bugs. Resident #37 stated, the staff "didn ' t wear gloves to serve medications before the state showed up. They even picked up pills off the floor and gave them to me." Resident #37 further stated, the staff did not close the door to the medication privacy to provide medications prior to the state arriving on / .
An interview on / at 11:55 AM was conducted with Resident #33. Resident #33 stated, she has to wait an hour for medications. She stated, she fears getting a 45-day discharge notice for talking to "the state." Resident #33 stated if they complain to the state they can get kicked out. She stated, the Administrator only acts nice in public.
On at 12:00 PM an interview was conducted with Resident #35. Resident #35 stated he used to have bed bugs in his , but they are gone. Resident #35 stated they had to spray his or 4 times. He stated, " when the place gets too bad with bed bugs they take us all to a hotel and tent it." Resident #35 stated, he has to wait a long time for his medications. He stated, they have to line up and wait. Resident #35 stated he also fears getting a 45-day discharge notice for complaining to the state. Resident #35 stated, yesterday ( ) and today ( ) "was the first time in a long time I have seen them wear gloves to hand out meds. They didn't do that or close the door until the state came. "

Class II

0055 Medication - Storage and Disposal

Based on observation and interview, the facility failed to appropriately secure prescribed resident medication. This was evidenced by the failure to centrally store injectable medications and supplies for residents in the designated 3rd party provider ' s office at the facility.

The findings include:

In an observation on at 9:10AM, the office door titled " Activity Director " was observed unlocked and opened slightly. A steady stream of residents were observed to be ambulating/ standing by the door as they waited for their morning medications.

Upon entering the office, no personnel were observed inside the office space. The surveyor observed numerous plastic bins with resident ' s names and inside the bins were medical supplies and injectable medications. A small refrigerator with an open lock attached was observed to have numerous

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910386	06/22/2016
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)

bottles of and pens inside. On the counter medical supplies including syringes and partially filled biohazard waste containers were observed.

In an interview with the Executive Director and Administrator on at 9:15 AM they stated that the office was being utilized by the Home Health nurse, whose responsibility was to administer to the residents at the facility. The Executive Director stated that her expectations were that all 3rd party providers follow the facility policy to keep the locked and secure the medications when personnel are not physically present.

Class III

0078 Staffing Standards - Staff

Based on record review and interviews, the facility failed to provide documentation that 1 of 6 Staff (Staff H) had written documentation from a health care provider the staff member was free of signs or symptoms of communicable within the required 30 days of date of hire.

Findings include:
In a record review on of Staff H ' s employee file, the file documented Staff H ' s date of hire was / . The file did not provide documentation of Staff H having a written statement from a health care provider as being free of signs or symptoms of communicable within 30 days of the date of hire.

In an interview on / at 8:51 AM with the Executive Director, it was requested the Executive Director provide documentation of Staff H having a written statement from a health care provider as being free of signs or symptoms of communicable within 30 days of the date of hire.

In a record review on / of the additional items regarding Staff H ' s employee file, the file did not provide documentation Staff H had completed the written statement from a health care provider as being clear of signs or symptoms of communicable within 30 days of the date of hire.
Class III

0160 Records - Facility

Based on record reviews and interviews, the facility failed to maintain an up-to-date admission and discharge log.
Findings include:
In a record review on / of adverse incident reports, the report documented Resident #2 stopped

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SUMMARY STATEMENT OF DEFICIENCIES
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breathing and on 6/12/16.
In a record review on 6/15/16 of the facility's admission and discharge log, the log did not show Resident #2 as having left the facility.
In an interview on / at 10:50 AM with the Administrator, the Administrator stated the admission and discharge log reviewed was complete and accurate.

Class III

Z816 Background Screening-Compliance Attestation

Based on record review and interviews, the facility failed to ensure 1 of 6 Staff (Staff C) had an updated level 2 background screening after a 90- day break in service. Based on record review and interviews the facility failed to ensure 1 of 6 staff (Staff H) had completed a level 2 background screening every 5 years.
Findings include:
In a record review on / of Staff C ' s employee file, the file documented Staff C date of hire as . The file documented Staff C had completed the required level 2 background screening on .
In an interview on at 8:51 AM with the Executive Director, it was requested the Executive Director provide documentation of a job application for Staff C.
In a record review on of the job application of Staff C, the job application of Staff C documented Staff C had worked out of state from to .
In an interview on at 2:30 PM with the Administrator, the Administrator stated the background screening web site showed Staff C had a level 2 screen.
In a record review on of Staff H ' s employee file, the file documented Staff H date of hire as / / . The file documented Staff H had completed a level 2 background screening on while employed by another health care provider.
In a record review on of the agency background screening web site, the web site documented Staff H completed an updated level 2 background screening on , more than 30 days after the level 2 background screen expired.
In an interview on at 8:51 with the Executive Director, it was requested the Executive Director provide documentation of Staff H having completed an earlier level 2 background screening.
In an interview on at 2:30 PM with the Administrator, the Administrator stated she followed the information on the background screening web site.
Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
City Walk Active Living
534 Datura Street
West Palm Beach, FL 33401
RE: CCR #2016004973

Dear Feuerman:

This letter reports findings of complaint investigations conducted from to and by representatives of the Agency for Health Care Administration. You are directed to comply with the tangible steps outlined below in order to correct the deficient practices. Attached are the deficiencies noted in the investigation.

The inspection resulted in findings of non-compliance in the following areas:

A 25 – Supervision – Class II. The facility failed to provide care and services appropriate to meet the needs of residents who had verbal limitations and experienced changes in condition. The facility failed to ensure that all residents were safe and failed to provide supervision after a resident had multiple or .

A 30 – Resident Rights, Physical Environment - Class II. The facility failed to provide a safe and decent living environment which was free of bed bugs and roaches, and failed to provide access to private communication.

Z 816 – Background Screening – Unclassified. The facility failed to ensure all staff had an updated level 2 background screening following a 90-day break in service, and failed to ensure staff had completed a new level 2 background screening every 5 years.

Your facility must comply with the following related to the Class II deficiency. Please be advised your facility is also expected to correct all other outstanding deficiencies:

1. To ensure the facility is pest and bug free, it must contract with a State licensed pest control company which will evaluate and treat the facility in its entirety, including the treatment of bed bugs. This must be completed by .

2. The facility must follow the licensed contractor's directions including, but not limited to, having tontemporarily relocate each resident from their another available

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SlideShare.net/AHCAFlorida

the facility or relocate residents temporarily outside the facility to ensure the residents are in an environment free of bedbugs and other pests. This must be completed by .

3. The facility must seek specific written direction from the licensed contractor to determine the individual resident procedure, including the handling of each and every resident's personal belongings. If the licensed contractor will require that each of the resident's clothing or personal items must be treated in high heat, the facility must log every resident's item undergoing this process. This must be completed by

4. The facility must provide documentation that it has followed the licensed contractor's procedure to achieve proper facility bed bug mitigation process. This must be completed by .

5. The facility must properly cover all of the gaps and spaces in or around its air conditioning units throughout the facility as part of having a pest-free environment for the facility residents. This must be completed by .

6. The facility must have a satisfactory health inspection from the Palm Beach County Health Department upon completion of treatment. This must be completed immediately upon completion of the licensed contractor's facility treatment. The inspection must be available for review by the Agency upon request.

7. The facility must develop and implement a policy and procedure to prevent future infestation of bed bugs that includes, at a minimum, the following:

   a. During intake interviews, ask questions regarding unexplained bite marks and ask about infestation at prior residences, including assisted living facilities.

   b. Prevent access to resident areas prior to the intake interview and inspection of clothing and belongings.

   c. Thoroughly inspect the resident's belongings for signs of infestation during the intake or upon resident return from any temporary absences from the facility.

   d. Launder patient clothing and belongings using high heat for drying if there are concerns about infestation.

   e. Discuss bed bug prevention with any health care providers coming into the facility and consider inspecting any medical equipment brought in.

   f. If the facility is concerned about an infestation, immediately prevent access to the affected , seal clothing and bedding in plastic until laundered and dried on high heat and inspect common areas frequented by the resident.

   g. The facility staff must be trained on the policy/procedures and documentation of the training must be available upon request. These policies and procedures must be completed .

8. The facility must update policies and procedures for promptly identifying and assessing residents who may have experienced one or more injuries incurred from witnessed or unwitnessed , changing medical conditions, or other factors. These policies and procedures must include the following elements:

   a. Identification of the parties responsible (all shifts) for conducting the assessment of resident appropriateness and needs upon a change of condition.

   b. A description of how these assessments and the resulting plans of action to prevent further injury or response to medical symptoms are identified, documented, and followed up.

   c. A description of how residents' medical concerns brought to any staff member's attention are shared with the management team and how the management team acts upon these reports from staff. Any symptoms that are not normal day to day observations of the resident (witnessed or unwitnessed , disturbances, aggressive behavior, etc.) must be reported to the management staff who will notify the health care provider for direction based on the observation.

   d. Procedures for implementing precautions and interventions and who is responsible.

   e. Implementation of a log and how witnessed and unwitnessed will be documented.

   f. Procedures regarding ongoing documentation in the medical file, including timely notification of family and health care providers regarding witnessed and unwitnessed . A description of how family or responsible parties are to be notified for residents that are unable to make their own health care decisions.

   g. The maximum timeframe for documenting the concern after it is first observed or reported.

   h. The required timeframe within which the follow up action must occur.

   i. The facility staff must be trained on the policy/procedures and documentation of the training must be available upon request. These policies and procedures must be completed .

9. The facility must provide a telephone that is available to residents on each floor of the facility that is in a private area and allows for private communication, or is a wireless telephone that can be taken to the residents' privacy. This must be completed by .

10. The facility must ensure all employees have a valid level 2 background screening, and ensure the facility is in compliance with all background screening requirements. This must be completed immediately.

City Walk Active Living
, 2016

Please be advised that nothing in this Directed Plan of Correction limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact Laura Manville, Assisted Living Enforcement Team Manager at 727-552-1955 or Tikle Wedges Phoenix, Assisted Living Supervisor, Area Field Office, at 561-381-5846.

Sincerely,

Arlene Mayo-Davis

Arlene Mayo-Davis

Field Office Manager

AMD/dso

D7JR

Received by:

Facility Representative Title Date

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