STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968090	08/05/2016
NAME OF PROVIDER OR SUPPLIER **PARK PLACE ASSISTED LIVING, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8200 SW 43RD TERRACE** **MIAMI, FL 33155**	

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

0000 Initial Comments

A complaint survey, CCR# 2016008904 was conducted on - at Park Place Assisted Living, License # 12042. The facility had deficiencies found 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 a resident who experienced a change in medical condition. This was evidenced by the failure to follow the preventative skin care instructions given by the 3rd party provider and failure to notify the provider of the resulting in multiple for 1 of 6 sampled residents, (Resident # 3) who was receiving hospice services.

The findings include:

Review of Resident #3's medical record indicated that the resident had the medical diagnoses of with loss of memory. The resident was alert only to name and required assistance with all of her activities of daily living (ADL) care, ambulation, eating, bathing, toileting and transfers. Further review of the record indicated that Resident #3 had experienced a decline in medical condition and was admitted to hospice services on with admission diagnoses including , and .
Review of the hospice nursing notes dated on indicated that Resident #3 was oriented to person only, non-ambulatory, with mobility and required assistance with all activities of daily living (ADL) care. The resident was of bowel and , and required staff to change her briefs frequently to keep the resident clean and dry and to monitor the area for breakdown. The resident's left hip was noted to have redness and repositioning and off -loading of the area was required to reduce pressure.
In an observation of Resident #3 on at 11:05 AM she was observed asleep lying on her back in a hospital bed. Both of the resident's feet had foam in place, a gauze dressing was observed on the right foot.
In an interview with the Consulting Administrator on at 11:05 AM that same time, she stated that Resident #3 had experienced a recent decline in medical condition which resulted in her admission to hospice services.
The Administrator stated on at 11:05 AM that Resident #3 was non-ambulatory, immobile and required staff assistance to transfer her to a wheelchair or recliner chair. The Administrator stated that she had been notified that Resident #3 had developed redness to the area, left hip and a was observed on the resident ' s right heel. She stated that the facility staff had been instructed by the hospice nurse to keep the resident in bed to facilitate repositioning and reduce risk of .

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Review of the facility's progress notes for Resident #3 dated on and indicated that the resident had a decrease in appetite and overall decline, becoming agitated and combative during care by facility staff and family. Further review of the notes indicated that on , Resident #3 was agitated and tearing at her diaper. The note indicated that the resident had redness on her "sacrum" area and scratches on her left hip and the hospice nurse had evaluated the resident's skin for breakdown. The note further indicated that due to the resident's decline in immobility, poor nutritional intake and concerns with , the hospice nurse recommended that Resident #3 stay in bed and be repositioned frequently by staff.

Review of additional hospice notes dated on , , and , Resident #3 had a poor appetite even after a menu consistency change, from pureed to regular diet. The notes indicated that the resident was to be encouraged to eat and observed to have no except for a healing on her right hand. The note documented that the nurse instructed the facility staff to reposition the resident every 2 hours to reduce risk of and to encourage the resident to take fluids.

Review of an additional hospice nurses note dated on indicated that Resident #3 had skin redness on her , a , measuring 2 x 2 cm. The left hip had redness, a with a measurement of 2 x 3 cm and on the right heel, an intact , an unstageable , measuring 4 x 3 cm. The nurses note indicated that the facility staff were instructed to monitor the resident's left hip and , to keep pressure off the left hip and to reposition the resident frequently all day and to encourage fluids. Further review of the note indicated that care was performed, and clear protective dressings were applied to both the left hip and . The nurse covered the right heel with foam dressing, along with use of protective . The note further indicated that the nurse instructed the staff to off load the right heel.

Review of the facility progress note dated on indicated that Resident #3 remained in bed and the dressing to the , and heel were in place. The note indicated that Resident #3 had removed the left hip dressing and the was noted as " scabbed over." Review of the facility note dated on / indicated that the hospice nurse did not visit that day. Further review of the notes indicated no documentation that facility staff had notified the hospice nurse or Administrator of any changes with the resident's skin integrity or removal of the dressings. Additionally, there was no documentation for review, that the staff had re-positioned the resident every 2 hours to reduce as instructed by the hospice nurse or the amount of fluid or nutritional intake consumed by the resident.

In an observation of Resident #3 on at 11:05 AM along with the Hospice nurse, the nurse was observed to perform care with assistance from the caregiver to hold the resident on her right side. The nurse removed the right heel dressing revealing a 3 x 3 cm, blackened with a bright pink peri- surrounding the entire . The skin surrounding the was observed to be dry with edges of skin that were lifting from the . The hospice nurse stated that the last time he had observed the heel , it was " an intact reddened ." The nurse proceeded to obtain assistance from the caregiver, to turn the resident on her right side and then loosen

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the resident ' s diaper, exposing a dime sized, open on the left hip, which was covered with white cream. The resident ' s area was observed to have no dressing attached and was bright red with 2 open areas, with the skin torn open, the entire was covered with a white cream/ ointment.
During the observation on at 11:05 AM, the caregiver stated that she was a new employee and had cared for the resident for only 2 days. She stated that she was able to position the resident on her side but the resident did not like to remain on her side. The caregiver stated that the dressing had come off with diaper changes, since the resident was . She stated that she had not notified the Administrator or hospice nurse of the . She stated that the white cream was barrier cream to protect the resident ' s skin.
In an interview with the hospice nurse at the same time on at 11:05 AM, he stated that he would need to contact the hospice physician immediately to obtain care orders. He stated that he had instructed the facility staff at each visit to reposition the resident every 2 hours, to change her diaper frequently, keeping her dry and off load the heels and use the foam . He stated that he had not been notified of any changes in the resident ' s condition over the past 4- day period and that he assessed the resident to have declined significantly since his last visit on .
In an interview with the Consulting Administrator on at 2:00 PM, she was asked for the documentation that the staff had followed the hospice instructions for repositioning the resident and the amount of nutritional/ hydration intake by the resident, she stated that there was no documentation. She stated that the facility staff had not notified the hospice nurse of the on the resident's and that she had not been notified by the staff of the resident's worsening .
Class II

0031 Resident Care - Third Partv Services

Based on observation, interview, and record review, the facility failed to coordinate with the third party provider to facilitate the receipt of care and services to meet the resident's needs. This was evidenced by the failure to develop, implement and document a facility policy for the coordination and oversight of third party services for 2 of 6 sampled residents, (Resident #3) on hospice services with worsening and (Resident #5) who required daily monitoring and with a history of .

The findings include:
1. Review of Resident #3's medical record indicated that the resident had the medical diagnoses of with loss of memory. The resident was alert only to name and required assistance with all of her activities of daily living (ADL) care, ambulation, eating, bathing, toileting and transfers. Further review of the record indicated that Resident #3 had experienced a decline in medical condition and was admitted to hospice services on with admission diagnoses including

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and .

Review of the hospice nursing notes dated on indicated that Resident #3 was oriented to person only, non-ambulatory, mobility and required assistance with all ADL care. The resident was of bowel and , the note indicated that the resident required staff to change her briefs frequently to keep the resident clean and dry and to monitor the area for breakdown. The resident ' s left hip was noted to have redness and repositioning and off -loading of the area was required to reduce pressure.

Review of additional hospice notes dated on , and , indicated that the hospice nurse instructed the facility staff to reposition Resident #3 every 2 hours to reduce risk of and to encourage the resident to take fluids.

Review of an additional hospice nurses note date on indicated that Resident #3 had skin redness on her , a , measuring 2 x 2 cm. The left hip had redness, a with a measurement of 2 x 3 cm and on the right heel, an intact , an unstageable , measuring 4 x 3 cm. The nurses note indicated that the facility staff were instructed to monitor the resident ' s left hip and , to keep pressure off the left hip and to reposition the resident frequently all day and to encourage fluids. The note indicated that care was performed, and clear protective dressings were applied to both the left hip and . The note indicated that a protective dressing was applied to right heel along with use of protective . The note further indicated that the nurse instructed the staff to off load the resident ' s right heel.

Review of the facility progress note dated on , indicated that Resident #3 remained in bed and the dressing to the and heel were in place. The note indicated Resident #3 had removed the left hip dressing and the was noted as "scabbed over." Review of the facility note dated on 8 / / , indicated that the hospice nurse did not visit that day. Further review of the notes indicated no documentation that facility staff notified the hospice nurse or Administrator of any changes with the resident ' s skin integrity or removal of the dressings. Additionally, there was no documentation for review, that the staff had re-positioned the resident every 2 hours to reduce as instructed by the hospice nurse or the amount of fluid or nutritional intake consumed by the resident.

In an observation of Resident #3 on at 11:05 AM along with the Hospice nurse, the nurse was observed to perform care with assistance from the caregiver. The nurse removed the right heel dressing revealing a 3 x 3 cm, blackened with a bright pink peri- surrounding the entire . The skin surrounding the was observed to be dry with edges of skin were lifting from the . The hospice nurse stated that the last time he had observed the heel , it was " an intact reddened ." The nurse proceeded to obtain assistance from the caregiver, to turn the resident on her right side and then loosen the resident ' s diaper, exposing a dime sized, open on the resident ' s left hip, covered with white cream. The resident ' s area was observed to have no dressing attached and was bright red with 2 open areas, with skin torn open, the entire was covered with a white cream/ ointment. (see photo evidence)

During the observation on at 11:05 AM, the caregiver stated that she was a new

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employee and had cared for the resident for only 2 days. She stated that she was able to position the resident on her side, but the resident did not like to remain on her side. The caregiver stated that the dressing had come off with diaper changes since the resident was . She stated that she had not notified the Administrator or hospice nurse of the or that the dressing had come off. She stated that the white cream was "barrier cream to protect the resident's skin. "

In an interview with the hospice nurse on at 11:05 AM, he stated that he would need to contact the hospice physician immediately to obtain care orders. He stated that he had instructed the staff at each visit to reposition the resident every 2 hours, to change her diaper frequently, keeping her dry and off load the heels and use the foam . He stated that he had not been notified of any changes in the resident's condition over the past 4- day period and that the resident had declined significantly since he last visited on .

In an interview with the Consultant Administrator on at 11:05 AM, she stated that Resident #3 had experienced a recent decline in medical condition which resulted in her admission to hospice services. The Administrator stated that Resident #3 was non-ambulatory, immobile and required staff assistance to transfer her to a wheelchair or recliner chair. She stated that on , the hospice nurse instructed the staff to keep the resident in bed to facilitate repositioning due to skin redness on the resident ' s , left hip and right heel.

In an additional interview with the Consulting Administrator on at 2:00 PM, she was asked for the documentation that the staff had followed the hospice instructions for repositioning the resident every 2 hours and the amount of nutritional/ hydration intake by the resident, she stated that there was no documentation. She stated that she was not aware if the facility staff had notified the hospice nurse of the dressing detaching or of the on the resident ' s . She stated that she had not been notified by the staff of the resident ' s worsening skin condition. She stated that the facility did not have any established policies and procedures that were implemented to adequately coordinate the care services between the resident ' s third party provider and the facility.

2. Review of Resident #5's medical record indicated that the resident was admitted with medical diagnoses including muscular , Charot-Morie- , and history of . Review of the resident's health assessment dated on indicated that the resident was alert and oriented and dependent for ambulation with use of a walker or a wheelchair. Further review of the assessment indicated that the resident was independent for eating, required supervision for self-care and assistance with bathing, dressing, toileting and transfers. The resident required twice daily and administration twice daily, both by the home health nurse.

Review of Resident #5's facility progress notes dated from to // indicated the resident had no changes in medical condition. Further review of the notes indicated that there was no documentation of any communication from the 3rd party provider to the facility regarding any observations of function or any monitoring results for glucose testing.

Review of Resident #5 ' s Medication Observation Record (MOR) dated and indicated the

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resident was prescribed and being administered , 5 units plus sliding scale dosage twice daily and Lantus , 8 units in the morning. Further review of the MOR revealed no documentation of daily glucose monitoring results.
Review of Resident #5 ' s Home Health Certification and Plan of Care dated on indicated that the resident "required daily assessment with special attention to and systems. " Further review of the plan indicated that the home health nurse will monitor vital signs and sugar levels via glucometer and report any complications to the physician. Additionally, the nurse will administer and Lantus daily as ordered by the physician orders. The plan further indicated that Resident #5 required " regular for emptying due to a diagnosis of . The nurse will insert a straight twice daily as ordered by the physician and assess for any signs or symptoms of , change in pattern elimination and report any complications to the physician. "
In an interview with the Home Health nurse on at 1:00 PM, she stated that she visited Resident #5 twice daily, to perform for and also to monitor glucose levels and administered . She stated that the resident had a history of . When questioned if she provided the facility with any documentation of her nursing assessments, observations and monitoring, she stated that she only signed the facility's MOR and did not leave any documentation of any observations she made. She stated that the facility staff are aware when she made her visits to the resident.
In an interview with the Administrator on at 1:30 PM, he stated that the facility did not have any internal policy or procedure concerning the coordination of care and oversight of the home health services required by Resident #5. He stated that there was no daily written documentation from the third party provider, other than the signed MOR. He stated that Resident #5 required nursing care twice daily for and administration. He was unable to provide any documentation of services performed by the third party provider, including the nursing assessment of the resident ' s condition with and the documentation of twice daily sugar monitoring. The Administrator stated that the third party provider had never provided any documentation of the daily observations and he had never requested the documentation for the resident's facility medical record.

Class II

specific role in the coordination of care within the facility. As part of the policy, the heath care provider visit notes must be maintained in the resident record. The facility must implement a written log for all residents receiving care from any third party providers. The log must include, at a minimum, name of resident who is receiving care, the name of the third party provider who is providing the care, and documentation of any care services and treatments completed including the course of the progress of care/ services rendered to the resident. **This requirement must be met by , 2016.**

3. The facility must review every resident's health assessment, documented on an AHCA Form 1823, to ensure it is complete and accurately reflects the resident's condition and the examining physician/physician extender's assessment. If the resident's health assessment does not accurately reflect the resident's current medical condition, the resident must be re-evaluated by a health care provider in a face to face medical examination. The facility must apply the resident assessment/records requirements herein for any and all residents admitted to the facility. **This requirement must be met by , 2016.**

Any required documentation set forth above which is not to be maintained on site and/or in resident records, should be directed to the attention Mrs. Verlande Exil, Health Facility Evaluator Supervisor and sent to:

Agency for Health Care Administration
Health Quality Assurance, Miami Field Office
Attention: Verlande Exil, Health Facility Evaluator Supervisor
8333 NW 53 St, Suite 300
Miami, FL 33166
Phone: (305) 593-3100
Fax: (305) 593 - 3121

Nothing in this Directed Plan of Correction limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Sincerely,

Arlene Davis, RN
Field Office Manager

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Park Place Assisted Living, Inc
8200 Sw 43rd Terrace
Miami, FL 33155

RE: CCR #2016008904

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2016 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 , 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 surveyor(s). Should you have any questions please call Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure
XG90

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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Raul Gonzalez, Administrator
Park Place Assisted Living
8200 SW 43rd Terrace
Miami, FL 33155

Dear Mr. Gonzalez,

This letter reports the directed plan of correction (DPOC) required to be met by this facility from the findings of a complaint inspection completed on , 2016 thru , 2016 by a representative of the Agency for Health Care Administration. **Your assisted living facility is directed to comply with the prescribed steps outlined below in order to correct the identified deficient practices.** Attached are the deficiencies cited during this inspection.

The investigation resulted in findings of noncompliance with the following areas:

A25 – Resident Care – Class II: The facility failed to provide proper care and services to meet the needs of the resident who was receiving hospice services and developed multiple

A31 – Third party services – Class II: The facility failed to coordinate and provide oversight with the third party provider to facilitate resident care and services.

Your facility must comply with the following:

1. The facility must create a policy to address communication with health care providers and family members/ responsible parties following a change of condition. Examples include but not limited to: any condition which required medical attention for example change in skin condition. The policy should include that the Administrator be notified immediately of any resident change and documentation be made in the medical record of all notifications and any orders or instructions given to the staff. The Administrator must have an active role in determining level of care options for the resident. All direct care staff must be trained on the new policy. Documentation of the training, content and sign-in sheet, must be maintained in the facility and available for review by the Agency upon request. **This requirement must be met by , 2016.**

2. The facility must develop and implement a policy and procedure for the coordination of care between third party providers and the facility. The policy must include who will be responsible for contacting and coordinating the third party providers, indicating how/when providers are notified of medical orders, specify notification instructions when the recommended care/ treatments are unable to be performed as ordered by the health care provider and how the facility will coordinate and provide oversight of the third party provider's care. The policy must address the facility's responsibility to document the coordination and oversight with the third party providers and the administrator's