STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967863	08/04/2016
NAME OF PROVIDER OR SUPPLIER **ROCKWELL SENIORS, INC II**	STREET ADDRESS, CITY, STATE, ZIP CODE **5030 NW 44TH AVENUE** **COCONUT CREEK, FL 33073**	

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

0000 Initial Comments

An unannounced re-licensure survey was conducted on 08/04/2016 at Rockwell Seniors, INC II (license 11864). The facility had deficiencies at the time of the visit.

0010 Admissions - Continued Residency

Based on record review and interview, the facility failed to ensure that all residents were reassessed after significant changes and that the Resident Health Assessment (AHCA 1823 Form) was accurate and reflective of the resident's care needs to ensure the resident met the criteria for continued residency, for 1 out 7 sampled residents (Resident #1).

The findings included:

Observations of Resident #1 on between the hours of 11AM and 3:30 PM, revealed she required total care. During an interview with Staff A at approximately 11:30 AM it was revealed the resident requires total care and receiving hospice services and care. Staff A also confirmed at times she transfers the resident by herself to and from the bed when she is working alone in the facility.

Record review of Resident #1's file revealed two AHCA 1823 completed within 30 days of her admission (admission). Review of both assessment revealed discrepancies in resident diagnosis, care needs and special precautions. The following was noted.
a) AHCA Form 1823 dated / documented diagnosis as ( ), (hypertention), (R) eye, , , (,), valve prolaspe. Physical or sensory limitations listed as right eyes, ambulate walker, two person assist. Nursing/treatment/ service requirements listed as eye drops, staples to right scalp from . Special precautions noted as risk. Activities of Daily Living (ADLs) listed as total with comments noted as 2 person with walker and two person with transferring. Under section C (status) documented the resident is bedridden and requires 24 hour nursing or care.

b) AHCA Form 1823 dated documented diagnosis as (Hypertention), WA, ICH (idiopathic cortical hyperstosis), ( ), (,), , MVP(micro valve prolaspe), , , (defribulation). Physical or sensory limitations listed as right eyes, ambulate walker, two person assist. Nursing/treatment/ service requirements listed as none. Special precautions noted standard . Activities of Daily Living (ADLs) listed assist for ambulation, bathing, dressing, toileting and transferring; eating noted as independent and self care ( ) listed as supervision. Under section C (status) documented all items as "no".

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967863	08/04/2016
NAME OF PROVIDER OR SUPPLIER ROCKWELL SENIORS, INC II	STREET ADDRESS, CITY, STATE, ZIP CODE 5030 NW 44TH AVENUE COCONUT CREEK, FL 33073	

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

During a review of the resident's hospice notes and progress notes revealed the resident was not enrolled into hospice until 7/22/16.
During an interview with the Administrator at approximately 1:30 PM on , the discrepancies with the AHCA Form 1823 was discussed. She acknowledged the differences and stated the resident was reassessed by the facility's in-house physician and a new 1823 was completed. It was also discussed with the Administrator based on the initial AHCA Form (dated) that the resident was inappropriate and didn't met the criteria for admission.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation, record review, and interview, the facility failed to ensure resident ' s rights by the use of physical for 1 out of 7 sampled residents (Resident #6).

The findings included:

On at 11:09 AM, revealed Resident #6 had full bed rails attached to bed. An interview was conducted with Staff A on at 11:30 AM, she stated the resident received the bed from a company, the company is no longer in business. She further stated the rails are used when the resident is in bed and she is unable to lift them up or down independently. Reviewed Resident #6 ' s record, it revealed no physician order for 1/2 bedrails.

These findings were discussed with the Administrator at 3:25 PM, she acknowledged Resident #6 full bed rails and stated resident ' s family bought the bed when resident was admitted.

Class III

0052 Medication - Assistance with Self-Admin

Based on observation, the facility failed to ensure unlicensed staff providing assistance with self-administration to the residents followed the appropriate steps and procedures during this task, for 1 out of 7 sampled residents (Resident #2).

The findings included:

During observation on at 12:05 PM, Staff A (unlicensed staff) provided assistance with

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967863	08/04/2016
NAME OF PROVIDER OR SUPPLIER **ROCKWELL SENIORS, INC II**	STREET ADDRESS, CITY, STATE, ZIP CODE **5030 NW 44TH AVENUE** **COCONUT CREEK, FL 33073**	

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

self-administration to Resident #2. Staff A gave the resident the medication but did not state the name of the medication. During an interview with Staff A, at this time, she was asked the name of the medication she stated, " medication ". Resident #1 also repeated the same statement.Review of Resident #2 ' s MOR (Medication Observation Record) at this time revealed the resident received Nateglinide (120mg tablet take 1 tablet by mouth three times a day at 8AM, 12PM, and 5PM).

These findings were discussed with Administrator and Staff A at approximately 1:00 PM. They acknowledged the findings.

Class III

0054 Medication - Records

Based on record review and interview, the facility failed to maintain an accurate and updated MORs (Medication Observation Records), for 2 out of 7 sampled residents (Resident #1 and Resident #3).

The findings included:
a) On at 12:05 PM, the 2016 MOR for Resident # 1 was reviewed and listed 2% drops, place 1 drop into both eye at bedtime at 8AM and 5PM. The MOR revealed no signature for at 8 AM. Staff A,at this time, stated the medication was given but not signed.

b) On at 12:05 PM, the 2016 MOR for Resident # 3 was reviewed and listed apply to affected area(s) twice daily at 9AM and 5 PM, 5% (700 mg/patch) ADH apply 1 patch to right leg every morning remove 12 hours later. The MOR revealed no signature for / at 9 AM. Staff A,at this time, stated the medication was given but not signed.

These findings were discussed with the Administrator and Staff A at this time and they acknowledged the unsigned MOR of Resident #1 and Resident #3.
Class III

0056 Medication - Labeling and Orders

Based on record review and interview, the facility failed to ensure all medications were filled in a timely manner and available for the residents, for 3 out of 7 sampled residents (Resident #2, Resident #3, and Resident #5).

The findings included:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967863	08/04/2016
NAME OF PROVIDER OR SUPPLIER **ROCKWELL SENIORS, INC II**	STREET ADDRESS, CITY, STATE, ZIP CODE **5030 NW 44TH AVENUE** **COCONUT CREEK, FL 33073**	

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

a) Review of Resident #2 ' s and 2016 MOR revealed the following medications; " Megestrol 400 mg/10 mL take 10ML by mouth twice daily (9AM and 5PM) and One Touch Ultra Test Strips test sugar 4 times a day (8AM, 12PM, 5PM, and 9PM). Further review of Resident #2 ' s MOR revealed no signatures for a mentioned medication indicating the resident had received assistance with the medications. During an interview with the Administrator at 12:20 PM on , she stated the medication was discontinued (d/c) because family refused to pay for medications for 2016 and 2016. The Administrator was asked to provide proof of the medications being discontinued. She stated she didn ' t have a d/c order. She further stated the order was d/c due to the resident ' s family member refusal to pay for the medications. The Administrator was asked for documentation of notification to Resident #2 ' s physician regarding this refusal; no documentation was provided.

b) On at 12:38 PM, the 2016 MOR for Resident # 3 was reviewed and listed apply to affected area(s) twice daily at 9AM and 5 PM, 5% (700 mg/patch) ADH apply 1 patch to right leg every morning remove 12 hours later . The MOR revealed no signature. Interviewed the Administrator at 12:38 PM on , she stated the medication was d/c because family refused to pay for medications for 2016 and 2016. During further interview, at this time, the discharge order was requested; the Administrator stated she did not have an order available.

c) On at 12:43 PM, the 2016 MOR for Resident #5 was reviewed and listed 25 mg tablet, take ½ tablet by mouth every 12 hours 8:00 AM and 8:00 PM . The MOR revealed the 8:00 AM medication was signed daily but no signature for the 8:00 PM medication. Interviewed Staff A, she stated the medication is provided once a day. A review of the medication label revealed the same order, and MOR 2016 revealed the medication was provided and signed twice a day.

These findings were discussed with the Administrator at 3:25 PM. The Administrator acknowledged the findings.

Class III

0079 Staffing Standards - Levels

Based on record review and interview, the facility failed to maintain a written work schedule which reflects the facility ' s 24 hour staffing pattern for a census of 7 residents. This was evident in that the facility failed to list the accurate hours, for 2 out 6 sampled staff members (Staff B and Staff E).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967863	08/04/2016
NAME OF PROVIDER OR SUPPLIER **ROCKWELL SENIORS, INC II**	STREET ADDRESS, CITY, STATE, ZIP CODE **5030 NW 44TH AVENUE** **COCONUT CREEK, FL 33073**	

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

The findings included:

On 08/04/2016, the written work schedule was requested at approximately 11:15 AM. The schedule revealed the shifts for Staff A, Staff C, and Staff F for the month of 2016. The schedule notes Staff A (7am-7pm) and F (6am to 12pm) to work on . Upon arrival to the facility at 10:30 AM on , the only staff member present was Staff A. At approximately 11:30 on / , the Administrator arrived with Staff D, whom was not scheduled to work. According to the Administrator, Staff F was scheduled to work but was off on this day, Staff D was to replace F.

Further review of the schedule for / revealed no staff was schedule to work after 7pm until 7am on . It was also noted that the Administrator hours (Staff C) was not on the schedule. During an interview with her at 11:45 am on , she confirmed that she works various hours within the facility provided care and services; she also confirmed Staff D was a new hire (hired on). Staff D was not listed on the schedule.

Class III

0093 Food Service - Dietary Standards

Based on record review and interview, it was determined the facility failed to ensure menus are dated and posted prior to the meal being served.
The findings included:
On , the facility menu was observed posted on the board in the corner of the kitchen. Further observations of the menus revealed a 4 week cycle menu (Week #1-#4) that was not dated with the corresponding week.

During an interview with the Administrator and Employee A at 11 AM, it was revealed that she forgot to date the menu and that the facility was on cycle #1.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview, the facility failed to maintain a safe living environment for 3 out of 7 sampled residents (Resident #4, Resident #6, and Resident#7).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967863	08/04/2016
NAME OF PROVIDER OR SUPPLIER ROCKWELL SENIORS, INC II	STREET ADDRESS, CITY, STATE, ZIP CODE 5030 NW 44TH AVENUE COCONUT CREEK, FL 33073	

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

The findings included:

On 08/04/2016, a tour was conducted at 10:57 AM. The bedrooms (Bedroom #2, Bedroom #4, and Bedroom #5) revealed unbolted headboards not secured. The headboards were loose and slightly leaning over the beds (photo included). During an interview with the Administrator at 11:30 AM, she acknowledged the unbolted headboards in each resident ' s . These findings were also discussed at 3:25 PM on .

Class III

Z814 Backaround Screenina Clearinahouse

Based on interview and record review, the facility failed to ensure that 6 out of 6 sampled staff (Staff A, Staff B, Staff C, Staff D, Staff E and Staff F) employment status was maintained and reported to the clearinghouse.

The findings included:

On at 10 AM, the facility staffing schedule was requested and reviewed. The Schedule showed a total of 3 staff members (Staff A, C, F). During an interview with the Administrator it was revealed Staff B and E were not on the schedule. She indicated Staff B just started on / and Staff E only does laundry in the facility.

Observations between the hours of 10:30 AM and 3:30 PM, revealed Staff B was providing direct care to the residents within the facility and Staff E was doing laundry of the residents in the facility laundry (located inside the facility).

On at approximately 2:00 PM, the employee roster was reviewed it did not list any employees for the facility. During an interview with the Administrator at 2 PM on , she stated that she is not maintaining the clearinghouse roster for the employees. The findings were discussed with the Administrator at 3:25 PM and she acknowledged the findings.

Unclassified

Z815 Backaround Screenina: Prohibited Offenses

Based on record review and interview, the facility failed to ensure that 1 out of 5 sampled staff (Staff E) employed at the facility was in compliance with the Level II criminal background screening requirement.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967863	**08/04/2016**
NAME OF PROVIDER OR SUPPLIER **ROCKWELL SENIORS, INC II**	STREET ADDRESS, CITY, STATE, ZIP CODE **5030 NW 44TH AVENUE COCONUT CREEK, FL 33073**	

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

The findings included:

The employee file for Staff E was requested on 08/04/2016 at approximately 2:00 PM. The file was reviewed for documentation of compliance with the Level II criminal background screening requirement. There was no documentation of this screening on file, and also no record on the Agency ' s background screening website. An interview was conducted at approximately at 2:15 PM, the Administrator stated the employee was recently hired. The findings were discussed with the Administrator at 3:25 PM, and she acknowledged that she was unable to provide a completed background screening for Staff E.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Rockwell Seniors, Inc Ii
5030 Nw 44th Avenue
Coconut Creek, FL 33073

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/jw

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