| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11964856 | 09/07/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**BROOKDALE TEQUESTA** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**211 VILLAGE BLVD**<br>**TEQUESTA, FL 33469** | |

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

**0000 Initial Comments**

An unannounced Relicensure with Limited Nursing Services (LNS) survey was conducted on 6th and 7th, 2016 at Brookdale Tequesta (License #9321). The facility had deficiencies at the time of the visit.

**0010 Admissions - Continued Residency**

Based on observation, record review and interviews, the facility failed to monitor the continued appropriateness of residency in this assisted living facility (ALF), for 2 out of 2 sampled residents (Residents #11 and #1).

The findings included:

1. A) On / at 9:00 AM, the Health and Wellness Director (HWD) stated during interview that there might be a resident at the facility who had a pressure , "but they (the resident) would be on hospice". She returned with a census (list of current residents) and stated Resident #11 "has a pressure " on her left hip.

On between 9:30 AM and 12:00 PM, Resident #11 was observed seated upright in a high back wheelchair with a cushion on the seat. Upon introduction, the resident only mumbled incoherent words while grabbing items in front of her, and had her eyes open. She was unable to make her needs known. Observation of the resident in her 1:30 PM on was made. The resident was laying in bed on her right side facing the wall with a pillow wedged behind her, which appeared to be for positioning.

During a subsequent interview on / at 12:30 PM, the HWD confirmed that Resident #11's pressure on her left hip was "a ". Review of the "Weekly Interdisciplinary Team Meeting Notes" at this time showed Resident #11 had a pressure on her left hip documented on and with a start of care date for the .

B) Review of the resident's record revealed the resident had a pressure with care to her left hip documented on the following physician's orders:

1) , "Patient may stay up after breakfast. Put to bed after lunch and dinner. Up for all meals."
2) / , "Irrigate ...pack with 1/2" gauze soaked with therahoney and powder. Apply sterile then non-sterile dressing...Change Monday, Wednesday and Friday and PRN (as needed)".

The facility's "Resident Log" noted:

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1. 5/16/16, the resident had a "redness- on left hip...home health will follow". 2. , "nurse wanted resident to reposition every 2 hrs".
No documentation of this is present in the plan of care, or shown as a provided care.
3. / , "resident seen by onsite ...nurse stated not improved"

The "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", with hospice start of care on , indicated the following:

1) / / , Medical Director, " incontinence and fecal incontinence. Unable to bear weight. Non-ambulatory. Only oriented to self."
2) / / , Registered Nurse/RN, "Patient is non-weight bearing and contracted at the knees. of bowel and . Requires with all ADLs."

The current "Personal Service Plan" dated , a care plan developed by the ALF, was also reviewed and showed the following interventions related to the resident's pressure :

1) : Remind resident to go to the needed. Remind resident to change protective undergarments as needed.. Assist with pulling pants up and down. Assist resident using the : approximately every 2 to 4 hours during the day and as needed during the night.
2) Skin Care: Resident has a . Refer to the Nutritional At Risk program related to open areas. Refer to the Open Area Flow Sheet.
a) The "Nutritional At Risk program Intervention Guideline" listed various tasks to increase calories in a resident's diet for healing. The guideline also listed tasks to increase protein in a resident's diet for healing.
b) The Open Area Flow Sheet was a form used to document weekly progress for wounds. The last flow sheet dated / was reviewed and showed documentation of a " Pressure ", and had " " pressure circled under "appearance" with a date of / documented as the "Date Open Area Identified".

A plan of care for staff at the ALF to follow related to the resident's extensive care needs, with interventions to prevent further and to address care, could not be identified in this plan of care. There was no indication that what was identified as the "plan of care" had been developed and implemented in consultation with hospice and the facility. The HWD was not able to identify the resident's individual care needs in the hospice "plan of care" or the facility's "personal service plan".

The hospice plan of care, identified by the HWD as the "Hospice IDG Comprehensive Assessment and

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Plan of Care Update Report" with a start date of , was in the resident's record but did not indicate additional care instructions for ALF staff to adhere to in order to prevent pressure sores or to enhance the healing of the current pressure . The plan was reviewed and included the following to address the resident's extensive care needs for turning and repositioning and care:

1) Home Health Aide provided 1 time a week for 1 week; 2 times a week for 12 weeks; 1 time a week for 1 week.
2) Skilled nurse visits 1 time a week for 1 week; 3 times a week for 12 weeks; 1 time a week for 1 week.

C) During interview with the Administrator on at 12:05 PM, she stated that she was "not aware of the resident's pressure ". The HWD stated she had known about the pressure for a "few weeks" since she started working at the facility. During interview with Staff G on at 11:30 AM, she stated there were no instructions to follow related to repositioning Resident #11, "only to change her" brief every 2 hours. Staff B stated during interview on / / at 4:00 PM that the resident was supposed to "stay off her left side" but staff at night "did not have enough time to check since almost all of the residents are and had to be changed" (40 residents). She stated only 2 staff were available at night to care for all of the residents, so they "can't check every 2 hours". Additionally, Resident #11 is a "2 person assist" for ADL's (activities of daily living) since she is not able to reposition herself with assistance.

D) Review of the resident's health assessment (AHCA Form 1823) dated showed the resident's diagnoses as ( ), and Memory Loss. Her cognition and behavioral status listed "poor memory". Physical or sensory limitations were documented as " hearing, wheelchair to ambulate". All ADL's on page 2 indicated the resident required "assistance", except eating for which the resident required "supervision". In the "comments" section where the type of assistance or care is to be documented for toileting, there were no details about the frequency or extent of care for this resident who was no longer assisted with toileting due to the resident's total status. The assessment documented " left hip" under the pressure inquiry.

E) Although Resident #11 was determined to be ill and was admitted to hospice with a start of care date on , the resident's extensive care needs with a nonhealing pressure , deemed this resident inappropriate for continued residency at this ALF due to the facility's failure to develop a plan of care that was coordinated and implemented in consultation with hospice and the ALF staff to address the additional care needs and to ensure the services were provided.

These findings were discussed with the Administrator and HWD on / at 3:30 PM. They confirmed that the resident had not been given a "45 day notice of relocation" at any time since the onset of the pressure in 2016. The Administrator acknowledged she was not aware that the

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resident had a pressure . There was insufficient documentation indicating the coordination and provision of care and services by ALF staff in conjunction with hospice to ensure continued residency. No additional documentation was presented at this time.

2. The review of medical record for Resident #1 reveals this resident was admitted to the facility on / with a primary diagnosis of / . The last health assessment (AHCA Form 1823) contained in Resident #1's record was dated / / .

On , Resident #1 had been admitted to Hospice which represents a significant change, per regulatory definition. When a resident experiences a significant change, a face-to-face examinaton with a health care provider is required, with results documented on a new health assessment (AHCA Form 1823). Resident #1 did not have a new health assessment completed after being admitted to Hospice on .

Class III

**0084 Trainina - Assis Self-Admin Meds & Med Mamt**

Based on employee record review and staff interview, the facility failed to ensure 1 of 3 sampled direct care staff and "med tech" (Staff B) obtained the initial 4 hours medication training provided by a licensed registered nurse or licensed pharmacist on assisting with self-administered medications and safe medication practices in an assisted living facility.

The findings included:

On , during employee record review for Staff B (hire date / ), there was no documentation contained within this employee's file, or provided by administration, showing completion of the regulatory required initial 4 hour training on assisting with self-administered medications. Staff B is listed on schedule as the 2nd shift (3:00 PM-11:00 PM) "Med Tech", an employee who is qualified and able to provide assistance with self-administration of medication.

An interview was conducted with the Health and Wellness Director (HWD) on at approximately 1:30 PM. At this time, the HWD acknowledged the missing documentation and that Staff B was scheduled as the shift "Med Tech". After checking with the Business Office, the HWD could not provide

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any additional information or documention showing completion of the medication training by Staff B.

Class III

**0086 Training - ADRD**

Based on employee record review and staff interview, the facility, which is a secured memory-care facility, failed to ensure 2 of 3 sampled direct care staff (Staff A and C) received the required and Related (ADRD) Level I training, provided by an approved within 3 months of hire.

The findings included:

On , during employee record reviews for Staff A (hire date ) and Staff C (hire date / ), there was no documentation contained within these employees' files, or provided by administration, showing completion of the regulatory required 4 hour ADRD Level I Training within 3 months from date of hire, and provided by an approved ADRD trainer. This initial training must address the following subject areas:

1. Understanding and related ;
2. Characteristics of ;
3. Communicating with residents with ;
4. Family issues;
5. Resident environment; and
6. Ethical issues.

An interview was conducted with the Health and Wellness Director (HWD) on at 1:30 PM. At this time, the HWD acknowledged the missing documentation. After checking with the Business Office, the HWD could not provide any additional information or documention showing completion of the Level I ADRD training conducted by an approved ADRD trainer within 3 months of hire for Staff A and C. No additional documentation was presented at this time.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Brookdale Tequesta
211 Village Blvd
Tequesta, FL 33469

**RE: Relicensure Survey**

Dear Administrator:

This letter reports the findings of a Relicensure survey with Limited Nursing Services (LNS) that was conducted on , 2016 and , 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
Enclosure

XG90

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