| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11968683 | 09/22/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**BANYAN PLACE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**2950 NW 5TH AVENUE**<br>**BOCA RATON, FL 33431** | |

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

**0000 Initial Comments**

A biennial Relicensure survey was conducted at Banyan Place on (license#12548). The facility had deficiencies identified at the time of the survey.

**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 1 out of 2 sampled residents (Resident #2).

The findings included:

Resident #2 was admitted to the facility on . Review of the resident's health assessment (AHCA Form 1823) dated showed the resident's diagnoses as (), (), (), (), Type II (), Lung () and (). His cognition and behavioral status were listed as " , forgetful, alert and oriented x2, disoriented to time and place". Physical or sensory limitations were documented as "right sided ; contracted lower extremities ". All ADL's (activities of daily living) on page 2 indicated the resident required "assistance". 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 "no pressure sores" under the pressure inquiry.

On at 9:45 AM, the Administrator stated during interview that there were no residents at the facility who had pressure sores.

On at 12:00 PM, Resident #2 was observed seated in a recliner in his a bandage on his right heel and the middle outer edge of his right foot. Upon introduction, the resident was alert with seconds of sleepiness (head lowered with eyes closed) and said "yes" but was not able to respond appropriately to questions. He was unable to make his needs known.

During an interview with the LPN (licensed practical nurse) and the Assistant Administrator on at 12:30 PM, they confirmed that Resident #2 had a pressure on his sacrum (tailbone area) that was a since 2016. The LPN also stated the resident had 2 additional pressure sores on his right foot with an unknown date of onset. The Assistant Administrator stated he was not aware of the two foot wounds. Review of the "Hospice IDG Comprehensive Assessment and Plan of Care Update

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Report" at this time showed Resident #2 had a pressure on his (tailbone area) documented on / and / with a start of care date for the not recorded. The report also noted care to a "right foot " and the "right ankle has dry scab, resolved no dressing needed" (dressing was observed on his right ankle). There was no documentation to show whether or not the foot wounds were pressure sores and the date of onset for care.

Review of the resident's record revealed no documentation by the facility related to the resident's three (3) pressure sores. The LPN was asked for any documentation of the pressure sores, including a health assessment (AHCA Form 1823) or any observation notes to show the facility staff's additional care provided to prevent or reduce the worsening of the pressure sores. The LPN was unable to locate any facility documentation related to the resident's pressure sores.

The "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" dated / was identified by the LPN as the "interdisciplinary care plan developed and implemented in consultation with the facility". The plan indicated the following:

a) Registered Nurse/RN, "Patient is alert and oriented x1 to 2, disoriented to time and place, forgetful; patient on 2 to 3L (liter) nasal cannula; right leg contracted; requires major assist with ADLs; on thickened liquids due to difficulty swallowing. precautions reinforced and education provided; patient is of bowel and ; to ; right foot cleanse; right ankle has dry scab, resolved; ALF staff instructed to reposition and offload the extremities to reduce and prevent [illegible].

The hospice plan of care, identified by the LPN as the "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" with a start of care date , was in the resident's record but did not indicate specific additional care instructions for ALF staff to adhere to in order to prevent pressure sores or to enhance the healing of the current pressure sores. The plan 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 1week; and, 14 times a week for 2 weeks.
2) Skilled nurse visits 3 times a week for 1 week; and, 14 times a week for 1 weeks.

During a subsequent interview with the Administrator on at 1:15 PM, he acknowledged that he was not aware of the resident's pressure sores. The Assistant Administrator stated at this time that he had known about the pressure on the resident's since 2016, but was unaware of the 2 additional wounds on the resident's right foot.

Although Resident #2 was determined to be ill and was admitted to hospice with a start of

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care date on 5/7/16 prior to admission to this ALF, the resident's extensive care needs with a nonhealing pressure and 2 additional pressure sores, deemed this resident inappropriate for continued residency at this ALF due to the facility's failure to develop a plan of care that was developed and implemented in consultation with hospice and the ALF staff to specify the additional care needs for facility staff and to ensure the services were provided.

These findings were discussed with the Administrator and Assistant Administrator on at 1:15 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 he was not aware that the resident had a pressure . There was insufficient documentation indicating the development 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.

Class III

**0093 Food Service - Dietary Standards**

Based on observations, record review and interviews, the facility failed to ensure a therapeutic diet was prepared and served as ordered, for 1 out of 2 sampled residents (Resident #2).

The findings included:

Resident #2 was admitted to the facility on . Review of the resident's health assessment (AHCA Form 1823) dated / showed the resident's diagnoses included ( ) and . His cognition and behavioral status listed " , forgetful, alert and oriented x2, disoriented to time and place". All ADL's on page 2 indicated the resident required "assistance". The resident's diet to be served was listed as "soft diet with thickened liquids".

During observation of the resident during lunch on / at 12:45 PM, Staff A was observed preparing the resident's meal. She pureed (blended to smooth consistency) a bowl of lentil soup and gave the soup to Staff E who spoon fed this to the resident. The pureed soup was a thin consistency (not thickened). The resident coughed for several minutes after eating 3 bites of the spoon fed soup. Staff E then assisted the resident to drink water (not thickened) by holding the cup and tipping it into the resident's mouth. The resident was then assisted with a container of a supplement drink (not thickened). Staff A stated during interview at 1:00 PM that this was the resident's lunch.

During observation of the resident during lunch on / at 12:20 PM, Staff A and B were observed in

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the resident's room feeding the resident a pureed and thickened bowl of chicken soup. Staff B spoon fed this to the resident. The resident did not while eating this soup. Staff E then prepared a cup of water, adding thickener and immediately handed the cup to Staff B who assisted the resident to drink it by holding the cup and tipping it into the resident's mouth. The thickener label indicated non-milk based beverages should be served "30 seconds to a minute" after preparation to allow the thickener to thicken the liquid. Staff A and B acknowledged during interview at 12:25 PM that this soup and a supplement drink was the resident's lunch. When asked what consistency the liquids should be for this resident, Staff A stated "like jello".

During interview with the Assistant Administrator and the LPN (licensed practical nurse) at 12:30 PM on / , the Assistant Administrator stated that the resident was to be served a pureed diet with all of the regular menu items pureed by staff. The LPN stated the resident was to receive liquids as "honey thick" consistency. She was unable to locate any documentation in the resident's record to show what consistency the resident's liquids should be served. The Assistant Administrator stated he was not aware that the staff were serving the resident only soup for lunch rather than the approved dietician's menu as served to the other residents at the facility. The resident's therapeutic diet was not prepared and served as the health assessment indicated. No additional documentation was presented at this time.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Banyan Place
2950 NW 5th Avenue
Boca Raton, FL 33431

**RE: Relicensure Survey**

Dear Administrator:

This letter reports the findings of a Relicensure survey that was conducted on , 2016 through , 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 21, 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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