STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964446	**04/26/2017**
NAME OF PROVIDER OR SUPPLIER **ISLES OF VERO BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **1700 WATERFORD DRIVE** **VERO BEACH, FL 32966**	

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

0000 - Initial Comments

A Complaint Investigation, CCR #2017003664, was conducted on through at Isles of Vero Beach, license #9095. The facility had deficiencies at the time of the investigation.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record reviews and interviews, the facility failed to obtain the required AHCA Form 1823 (medical examinations) and Interdisciplinary Care Plans for 2 of 2 sampled Residents (#1 and #3) when they began receiving hospice services.

The findings included:

Review of Resident #1 and #3's records was conducted on with the facility's Administrator and Wellness Director (WD), a Licensed Practical Nurse, present. The following concerns were identified:

1. Resident #1 was admitted to the facility on . A Hospice Certification dated documented his principle diagnosis as Parkinson's . He began receiving hospice services on which represents a significant change in condition. Further record review revealed:

a. No documentation showing he received the required medical examination documented on AHCA Form 1823 which reflected his current health status.

b. No Interdisciplinary Care Plan, developed by hospice in consultation with the facility, which specifies services to be provided by hospice staff and services to be provided by assisted living facility staff , was located.

c. There was no Hospice Care Plan available for review.

2. Resident #3 was admitted to the facility on . A Hospice Certification dated documented his principle diagnosis as , of the . He began receiving hospice services on which represents a significant change in condition. Further record review revealed:

a. Pages 2, 3 and 5 of his AHCA Form 1823 dated , signed by an Advanced Registered Nurse Practitioner, were left completely blank. On at 10:36 AM, the facility presented an AHCA Form 1823 dated . Upon review, the following concerns were noted:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964446	**04/26/2017**
NAME OF PROVIDER OR SUPPLIER **ISLES OF VERO BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **1700 WATERFORD DRIVE VERO BEACH, FL 32966**	

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

i. There was no reference to the resident receiving hospice services.
ii. The resident's height and weight listed "unknown".
iii. The special precautions section was left blank.
. There was no type of diet listed.
v. The level of assistance required for preparing meals and shopping did not reflect extent and type of assistance required.
There was no documentation showing he received a new AHCA Form 1823 medical examination reflecting his current health status.

b. Two "[Hospice] Interdisciplinary Plan of Care", developed by hospice staff, were reviewed:
i. One was dated and signed by hospice staff, but was not signed by facility staff to show it was developed in consultation with facility.
ii. The other was dated and included has "no [Home Health Aide] by hospice requested by [patient at] this time: facility CNA provides daily personal care".
Both forms did not adequately reflect the resident's individual and specific needs. They did not adequately identify services to be provided by hospice staff, and did not adequately identify services to be provided by assisted living facility staff. Also, there was no Hospice Care Plan available for review.

During the survey multiple requests for related documentation were made to the Administrator and WD throughout the survey conducted on . On at 10:36 AM, the facility provided related documentation that was inadequate. These concerns were discussed by telephone with the Administrator and WD on at 1:05 PM.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interviews, the facility failed to:
I. Provide supervision and assistance with activities of daily living (ADL) as needed, and failed to make timely notification for 1 of 3 sampled Residents (#1). A resident who needed total assistance with ADL's waited nearly 2 hours for assistance with positioning from facility staff, and hospice staff was not notified in a timely manner after an incident.
II. Ensure appropriate care and services were provided to 1 of 3 sampled Residents (#2). A resident receiving daily injections was assisted by a private Certified Nurse Aide (CNA).

The findings included:

I. Review of facility records and Resident #1's records revealed the following. He was admitted to the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964446	**04/26/2017**
NAME OF PROVIDER OR SUPPLIER **ISLES OF VERO BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **1700 WATERFORD DRIVE** **VERO BEACH, FL 32966**	

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

facility on as an assisted living resident; his spouse moved in with him as an independent resident. His AHCA Form 1823 (medical examination) documented pertinent diagnoses of Parkinson's , , high , and recurrent , . He requires total assistance with all ADL's. He began hospice services on .

An interview was conducted on at 8:47 AM with Resident #1's family member and Power of Attorney (POA). She provided the following information. On at about 3:40 AM, Resident #1's spouse pressed her wireless call pendant in order to get assistance to reposition him. His legs were hanging off the left side of his bed, and his head was against the right side rail and wall (pictures were provided by the POA). There was no response to the pendant calls, so the Spouse walked around the facility to find help and could not locate any staff. The Spouse then called other family members for help. Two other family members arrived at the facility around 4:30 AM and repositioned the resident. One of them unsuccessfully searched for staff on both floors of the facility, including the nurse station. Around 5:00 AM, Staff A and B, two facility CNA's, arrived at Resident #1's apartment. Resident #1's POA stated he went without staff assistance for about 1 hour and 38 minutes. Family members were told Staff A was with another resident, and she didn't know or hear where Staff B was during that time. She also stated facility staff advised her they had walkie-talkie type radios but they were not working.

In an interview conducted on at 10:37 AM, the Administrator and WD provided the following information. They use a wireless pendant call system. The resident pushes the pendant button, a signal goes out to all pagers carried by staff on duty and on a computer in the nurse station. Staff respond to the call, and after care is rendered, they clear the call directly on the pendant. All calls are time stamped and recorded in the system. (Staff G later stated only she and the WD have access to the system). Staff also have radios but they did not always work, the antenna covers and clips would break, there were weak or no signals at times. They presented 6 new radios that would be handed out to staff this morning.

In confidential interviews conducted from 1:00 PM through 4:07 PM, it was revealed all were familiar with and were upset regarding the incident. All used pagers and confirmed the incoming calls can be muted on the pagers. All believed they could use one more caregiver on each shift. All were familiar with the poor conditions of the radios, and were pleased to get the new ones. Comments made included, " ... have new radios, the old ones didn't work well", "There's no signal on the old radios.", and, " ... had horrible radios that didn't work."

Further review of facility records and Resident #1's records conducted and revealed the following:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964446	**04/26/2017**
NAME OF PROVIDER OR SUPPLIER **ISLES OF VERO BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **1700 WATERFORD DRIVE** **VERO BEACH, FL 32966**	

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

1. On at 12:25 PM, the WD advised the call report system was not able to print call records but offered to provide the requested information by viewing the computer monitor screen directly. At 4:07 PM, the WD and Staff G presented the call report information (photographic evidence obtained). Review of the call report revealed, on , more than 150 calls for assistance were generated from pendants used by both Resident #1 and his spouse beginning at 3:41 AM through 5:28 AM, almost two hours.

2. Employee Time cards for Staff A and B, the two staff members involved in the incident, documented the following:
a. Staff A punched out for a break on at 3:34 AM and punched back in at 4:04 AM.
b. Staff B punched out for a break on at 4:00 AM and punched back in at 4:30 AM.
Both staff members were punched out between 4:00 AM and 4:04 AM. Both were punched back in by 4:30 AM but Resident #1's calls for assistance were not responded to until 5:00 AM.

3. Documentation related to the incident consisted of:
a. A hand-written note dated documented a telephone interview between the WD and Staff B, "Says she went on break (didn't have pager) returned from break in her car, saw light on to [other resident]. Went to help her, they left [other resident] to [Resident #1's] and ran into daughter." Note, the call report system documented there were no calls for assistance activated from the "other resident's" between 3:41 AM and 5:28 AM.
b. A copy of a 5:50 PM text received from Staff A advised the WD, she would resign immediately to care for a family member.
c. Portions of five internal emails dated from at 11:43 AM through at 10:17 AM related to the status of the situation. On at 10:37 AM, an email from the WD included acknowledgement of the initial activation of Resident #1's pendant was at 3:21 AM. It also disclosed, "I have reached out to staff members and asked them to come in to discuss this situation with me." which indicates the two staff members on duty at the time of the incident, Staff A and Staff B, were not interviewed as of at 10:37 AM, more than two days after the incident occurred. There was no reference to the incident in the resident's Charting Notes. On at 1:18 PM, the WD was asked and stated this was all the documentation available.

4. Review of the facility's incident investigation forms revealed two forms:

a. A form titled "Incident Report (all incidents must be investigated)" included sections for:
i. Date, time, location of incident, residents involved, staff and visitors involved, contributing factors.
ii. Details related to part of body injured and medical assessment, type of occurrence.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964446	**04/26/2017**
NAME OF PROVIDER OR SUPPLIER **ISLES OF VERO BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **1700 WATERFORD DRIVE** **VERO BEACH, FL 32966**	

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

iii. Describe what you found/observed. Interview the resident and any witnesses and attach statements.
. Describe what happened, where it happened, how you think it happened, what immediate action was taken to prevent re-occurrence, was resident put on alert?
v. Notifying physician, were they seen by a physician or transferred to the hospital.
vi. Name/relationship of family/responsible party notifications, facility executive director notification.
vii. Name, title, address, telephone number of witnesses.
viii. Who the form was prepared by (must be filled out as soon as possible)".
viv. "Investigated by Resident Care Coordinator/Registered Nurse/Executive Director within two (2) business days; Signature, Title/Date".

b. A form titled "Investigation" included sections for:
i. Resident Name, Date, "Examples of health problems that can contribute to an incident ... Examples of Environmental factors that can contribute to incidents"
ii. Management Review and Investigation with 7 pertinent questions and actions.
iii. Summary of assessment of contributing factors.
. Action Plan/intervention to prevent further occurrences, signed and dated by Resident Care Coordinator and Executive Director.

On at 1:07 PM, the WD was asked and stated these forms were not used for this investigation. She stated the forms were in place before she was hired four months ago. The Administrator stated incidents reports are required for anything out of the ordinary.

II. On at 10:20 AM, the WD was asked to identify residents with specific conditions or needs, and to mark them on the printed census provided at the entrance conference. She circled Resident #2's name and added " - syringes - private caregiver". When asked for clarification regarding "private caregiver", was she an independent contractor or with an agency, the Administrator and WD stated they would look in to it.

On at 2:10 PM, Resident #2 was observed and interviewed in her apartment. She was asked about her medication routine and stated "the girls" bring it to her every morning. She thinks they store it for her. She wasn't sure if "the girls" were facility staff or from an agency. With permission from the resident, this writer inspected her refrigerator and observed an unlocked "lock box" stored on the refrigerator door which contained a vial of [ ] 32 [units, , every morning], and a "roll" of 3 syringe storage packets that were opened. Inside were 3 syringes that had been pre-filled with 32 units each of the . Written HCP orders dated called for " [32 units , every morning ... [sugar tests] daily", and calling for " - inject 32 units [,] every morning". This was brought to the attention of the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964446	04/26/2017
NAME OF PROVIDER OR SUPPLIER **ISLES OF VERO BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **1700 WATERFORD DRIVE** **VERO BEACH, FL 32966**	

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

Administrator and WD on at 3:59 PM. The WD later confirmed she removed the medication from the resident's .

Review of facility records and Resident #2's records revealed the following. She was admitted to the facility on . Her AHCA Form 1823 (medical examination) documented pertinent diagnoses to include II, chronic failure, chronic kidney , and high , . She has short-term memory loss at times and requires assistance with self-administration of medications. Page 5 documented Services Provided to Resident included medication management by Medication Technicians assisting with self-administration; the page was signed by facility staff on .

Both the facility's and Individualized Service Plans disclosed:
1. " - Resident receives assistance monitoring from a third party"
2. "Injections - Resident self administers injections"

Further review of Resident #2's records revealed no documentation showing she was approved for storing medications in her apartment and was issued by a Health Care Provider (HCP) such as a Medical Doctor, Physician Assistant, or Advanced Registered Nurse Practitioner.

Resident #2's and , 2017 medication observation records (MOR) documented an entry for the dated . Facility staff entered their initials daily which would indicate facility staff provided the scheduled doses. There were no notations on the MOR's such as "third party" or "home health nurse". On at 2:37 PM, Staff G, a Licensed Practical Nurse and the facility's "day nurse", reviewed this information, and confirmed these findings.

Her resident Charting Notes were reviewed back through , the following pertinent entries were noted:
a. A entry disclosed "home health assist with and injections"
b. A entry disclosed, " cont as ordered provided by homecare"
c. A entry disclosed, "Assistance with continues with care companions"
d. A entry disclosed, "private duty continues to assist resident with "

Concerns related to the facility allowing a private duty CNA to pre-fill syringes (which requires a skilled nurse) were discussed with the Administrator and WD on at 10:30 AM. They stated they did not know the private CNA was pre-filling syringes. They were asked and stated they did not know if the agency supplying the CNA knows about their CNA pre-filling syringes but they will call them. The "agency" turned out to be the private CNA who has been providing care to Resident #2 since

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964446	**04/26/2017**
NAME OF PROVIDER OR SUPPLIER **ISLES OF VERO BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **1700 WATERFORD DRIVE** **VERO BEACH, FL 32966**	

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

at 10:40 AM, the facility provided:
1. An undated confirmation for a Employer Identification Number and a Articles of Organization for a Florida Limited Liability Company. Both documents were related to the private CNA providing medication services for Resident #2.
2. A copy of Resident #2's private caregiver's current CNA certificate, and a copy of her current training related to assisting residents with self-administration of medications.
3. A Contract Agreement/Plan of Care prepared by Resident #2's private caregiver disclosed the following:
a. Special Instructions, "Get out of refrigerator and hand to patient. She will give to herself - Stand by assist"
b. "7 days per week [in the morning].
c. The section titled "Delegated Task will be Supervised by" is checked off for "Client" and "Responsible Party/Family Member. Resident #2 and the private CNA signed the form.

The facility's Personal Care Provider Rules of Conduct form included:
1. " ... some residents desire to obtain the services of individuals with whom they contract directly to provide specialized personal care ... home health care, personal care assistant, home health aide, companion, homemaker and caregiver. For the purpose of these rules of conduct, all such individuals shall was referred to here as "Personal Care Providers."
2. "Page 1, Item 2 Shall acknowledge the Personal Care Provider Rules of Conduct and provide this fully completed document to Community Management before commencing any service to any resident at the Community."
3. "Page 2, Item 13 Shall commit no intentional or reckless act or pattern of negligent acts that threatens the health, safety, or well-being of a resident or any other person at the Community."
Resident #2 and a facility nurse signed the form on ; the form was not signed by the resident's private caregiver.

These concerns were discussed with the Administrator and WD by telephone on at 1:05 PM.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interviews, the facility failed to ensure staff members who provide direct care to residents received required training for 3 of 4 sampled Staff (A, B and C). There was no proof staff received training in multiple required topics related to care and services in an assisted living facility

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964446	**04/26/2017**
NAME OF PROVIDER OR SUPPLIER **ISLES OF VERO BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **1700 WATERFORD DRIVE VERO BEACH, FL 32966**	

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

(ALF).

The findings included:

Personnel file review was conducted on with the Administrator and Wellness Director (WD) present at times. The following concerns were identified:

1. Staff A, a Certified Nurse Aide (CNA) and Medication Technician (MT), was hired on . Review of her personnel filed revealed no certificates of training showing she received the required 1-hour training in:
a. Resident rights in an ALF
b. Recognizing and reporting resident , neglect, and ,
c. Reporting major incidents and adverse incidents

2. Staff B, a CNA and MT, was hired on . Review of her personnel filed revealed no certificates of training showing she received the required 1-hour training in:
a. Resident rights in an ALF
b. Reporting major incidents and adverse incidents
c. Recognizing and reporting resident , neglect, and , .
Staff B's training transcript revealed an entry dated for training titled " and". The transcript did not include the:
i. Full title or subject of the training agenda program
ii. Number of hours of training she received
iii. Location of training program
. Training provider's name, dated signature, credentials, and professional license/certification number, if any

3. Staff C, a CNA and MT, was hired on . Review of her personnel filed revealed no certificates of training showing she received the required 1-hour training in:
a. Resident rights in an ALF
b. Recognizing and reporting resident , neglect, and ,
c. Reporting major incidents and adverse incidents. Staff C's training transcript revealed an entry dated for training titled "Adverse Incidents - /Flo". The transcript did not include the:
i. Full title or subject of the training agenda program
ii. Number of hours of training she received
iii. Location of training program
. Training provider's name, dated signature, credentials, and professional license/certification number,

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964446	**04/26/2017**
NAME OF PROVIDER OR SUPPLIER **ISLES OF VERO BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **1700 WATERFORD DRIVE** **VERO BEACH, FL 32966**	

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

if any

Multiple requests for training documentation were made to the Administrator and WD throughout the survey conducted on . On at 1:18 PM, the Administrator was asked and stated she believes none of the CNA's are core trained, and confirmed all CNA's provide direct care and services to the residents. On at 10:36 AM, the ALF presented related documentation that was inadequate as presented above. These concerns were discussed by telephone with the Administrator and WD on at 1:05 PM.

Class III