STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965201	05/24/2017
NAME OF PROVIDER OR SUPPLIER **ASSISTED LIVING OF PEMBROKE PINES**	STREET ADDRESS, CITY, STATE, ZIP CODE **1985 NW 179TH AVE** **PEMBROKE PINES, FL 33029**	

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

0000 - Initial Comments

A Relicensure survey was conducted on at Assisted Living of Pembroke Pines (License # 9567). The facility had deficiencies identified during this visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to have completed resident health assessments for 2 out of 2 sampled residents (residents #3 and 5.)

The findings are:

Review of resident #3's health assessment dated on indicated that he was diagnosed with with , cortical , right sided and unsteady gait. Review of this health assessment indicated that the resident was independent with ambulation and eating, and required supervision with his activities of daily living (ADLs), including bathing, dressing, , toileting and transfers. Further review of this health assessment indicated that there were no comments to explain the extent and type of ADL supervision the resident needed to receive from the facility staff.

Review of resident #5's health assessment dated on indicated that he was diagnosed with , and - . Review of this health assessment indicated that the resident was independent with eating and required supervision with ambulation and needed assistance with bathing, dressing, , toileting and transfers. Further review of this health assessment indicated that there were no comments to explain the extent and type of ADL supervision and assistance the resident needed to receive from the facility staff.

In an interview with the alternate administrator on at 2:30pm, she stated that the health assessments for residents #3 and 5 were not current and accurate because both residents required to presently receive assistance with their ADLs. She also stated that she was not aware that the facility was required to ensure that the residents' health assessment must be completed to include the physician's comments to explain the extent and type of ADL assistance or supervision each resident must receive in the facility.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, interview and record review, the facility failed to provide assistance with

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self-administration of medications for 1 out of 1 residents (resident #5).

The findings are:

Review of resident #5's 2017 medication observation record (MOR) indicated that he was prescribed one 80mg chewable tablet, three times daily before meals. Further review of this MOR indicated that the resident did not refuse to take any of his medication before .

In an observation on at 12:50pm the alternate administrator attempted to assist resident #5 with the self-administration of the resident's prescribed chewable tablet medication until the resident did not respond to any of the alternate administrator's verbal and prompting. It was observed at this time that the alternate administrator attempted to administer the resident's medication by holding the medication inside the souffle cup in her own hand, guiding the resident's hand with her hand and grasping the resident's hand so she actively approximated both of their hands containing the medication, towards the resident's mouth. It was observed that the resident did not take his medication orally because he presented to have no attention or understanding relating to the self-administration of his medication at this time and he was not physically able to perform the action to hold the medication in his hand to bring it towards his mouth. In an observation on at 1:05pm, the alternate administrator attempted to administer the resident's medication in the same form and manner as she did approximately 10 minutes before that day, and the resident did not take his medication orally because he presented to have no attention or understanding relating to the self-administration of his medication at this time and he was not physically able to perform the action to hold the medication in his hand to bring it towards his mouth.

Review of resident #5's health assessment dated on indicated that he was diagnosed with and . Review of this health assessment indicated that the resident needed assistance with self-administration of his medications from the facility staff.

In an interview with the alternate administrator on at 1:15pm, she stated that resident #5 sometimes had difficulty physically self-administering his own medications, which made it extra difficult for the facility staff to be able to assist with the resident's self-administration of his medications and this was the reason why she attempted to administer the resident's medication at approximately 1:00pm that day. She stated that the resident also was not always cognizant of when he needed to take his medications and the resident did not always understand the purpose for taking his medications due to his advanced neurodegenerative condition. She stated that the facility did not previously document when the resident was administered his medications and the facility did not previously notify his

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SUMMARY STATEMENT OF DEFICIENCIES
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physician when it was not possible to assist the resident with his self-administration of medications.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to provide current written statements from a physician to document that caregivers A and B did not have any signs or symptoms of communicable and to provide evidence of these staff members' current negative examinations.

The findings are:

Review of caregiver A's employee record indicated that she was hired on or about in a capacity to provide direct personal care to facility residents. Further review of this caregiver's record indicated that there was no current written statement from a physician to document that she did not have any signs or symptoms of communicable and there was no documented evidence of the staff member's current negative examination.

In an interview with the alternate administrator on at 11:20am, she stated that the facility did not have a current written statement from a physician to document that caregiver A did not have any signs or symptoms of communicable and there was no documented evidence that she received a negative examination.

Review of the manager's employee record indicated that she was hired on in the capacity to provide direct personal care to facility residents. Further review of this manager's record indicated that there was no current written statement from a physician to document that she did not have any signs or symptoms of communicable and there was no documented evidence of the staff member's current negative examination.

In an interview with the manager on at 11:25am, she stated that she did not have a current written statement from a physician to document that she did not have any signs or symptoms of communicable and she did not have current documented evidence of her negative examination.

Class III

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

Based on record review and interview the facility failed to provide documentation of compliance with the

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staff training requirements for caregiver A.

The findings are:

Review of caregiver A's employee record indicated that she was initially hired on or abut and she did not receive facility-specific in-service training for elopement response, emergency preparedness, incident reporting, resident rights, resident prevention and .

In an interview with the alternate administrator at 11:25am, she stated that the facility did not have proof to represent that caregiver A received the required facility-specific in-service training within 30 days of initial employment with the facility.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on record review and interview, the facility failed to ensure its staff members including caregivers A, B and manager, received the required assistance with self-administered medication and medication management training.

The findings are:

Review of caregiver B and the manager's employee records indicated that they did not possess a current certification for completion of assistance with self-administered medication and medication management course. Review of caregiver A's employee record indicated that she received a certification for completion of assistance with self-administered medication and medication management course dated on and it was signed by a licensed practical nurse.

In an interview with the alternate administrator on at 12:00pm, she stated that caregiver B and the manager's most recent completion of the assistance with self-administered medication and medication management course was on and respectively and that the facility did not have proof that they completed a more recent course. She stated that caregiver A's completion of assistance with self-administered medication and medication management course on was not valid since the course was not provided by a registered nurse or pharmacist. She stated that the facility expected all these staff members to be adequately trained in the assistance with self-administered medication and medication management because it was required that hey perform assistance with self-administered medications to the residents in the facility.

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Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to provide a safe and comfortable living environment to the residents by not ensuring its existing architectural systems and appurtenances were maintained in good working order.

The findings are:

In an observation on at 9:30am, the master 's shower presented to have its walls cut open with the interior exposed to indicate extensive water damage inside the walls. In an observation of the interior of the shower walls at this time there was extensive black-colored mold-like growth throughout and the shower and its surrounding area inside the , to be not in working order due to this damage.

In an interview with the alternate administrator on at 2:00pm, she stated that the master 's shower suffered water damage a few weeks ago and the shower was not in working order at that time. She stated that the rest of the master operational and that she did not know if the water damage inside the shower walls had caused mold growth and if it was safe to enter this . She stated that the facility had no yet received a written estimate from a professional contractor to evaluate the shower walls for mold and to repair the walls in order to make the shower functional again.

In an observation on at 3:15pm, the sliding doorway in the living to the patio was extremely difficult to open. In an observation at this time, the sliding doorway rail was obstructed with debris and dirt. In an observation on at 3:15pm, the bug screen covering the patio was ripped and had holes in it.

In an interview with the alternate administrator on at 3:20pm, she stated that she was aware that the sliding doorway rail was obstructed with debris and dirt, which made it very difficult to open this doorway. She stated that she was also aware that other areas in the patio and the exterior of the facility, including the bug screen, were not being maintained so as to provide a safe, comfortable and homelike environment to the residents.

Class III