STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911412	**05/09/2017**
NAME OF PROVIDER OR SUPPLIER **LIVEWELL AT COURTYARD PLAZA**	STREET ADDRESS, CITY, STATE, ZIP CODE **15520 NW 2 AVENUE** **NORTH MIAMI BEACH, FL 33160**	

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

0000 - Initial Comments

A complaint (CCR #2017003794) survey was conducted in conjunction with a Revisit Survey on May 2nd, 2017 until May 9, 2017. Livewell at Courtyard Plaza with limited mental health and limited nursing services components, license number 7169, had the following deficiencies identified at the time of the survey:

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation and interviews, the facility failed to provide a safe and decent living environment, and failed to treat 15 of 28 sampled residents with consideration, respect, and with due recognition of personal dignity, individuality, and the need for privacy for.

Findings Include:

Observation during the facility tour on at 9:44 AM showed that #34, #39, #43, #52 had three beds. Residents #1, #2, #3 (residing in #), #4, #5, #6 (residing in), #7, #8, # 9 (residing in #), #10,#11 and #12 (reside in #). The residents had their clothes in or on boxes in the .

On at 9:53 A.M. , observed at the entrance of door Resident 21 was in a plastic bottle behind a transparent patio furniture (chair). Staff A, the resident care director, was present performing a tour of the facility, and she acknowledged the incident. Staff A walked to # and called Staff M, certified nursing assistant (CNA) to assisted resident #21. Staff M arrived, held the resident hands walked into the , stating "he is legally and he needs our assistance for everything." Observed that resident was able to transfer with staff assistance inside # . Staff sat the resident in the wheelchair and stated "I will assist him with toileting." Staff A informed the CAN that the resident had plastic bottle with in his jacket pocket.

On at 10:00 A.M., observed in a common by # and #18 a black substance resembling feces on the toilet stool and in the shower. Staff A acknowledged the findings and called a housekeeper to cleaning the 10:03 a.m. In # , observed Resident #20 laying down on bed and stated "I need to go to the ." The resident repeated this several consecutive times. I When asked "Can you go on your own?", She stated "No I can't go by myself I need help". Observed the resident wearing an adult brief. Staff A, alerted housekeeping to clean the because resident #20 needed to go to the . Staff A called a CNA to assist the resident.

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At 10:05 A.M., # had strong smell, the Staff A, called house keeper and stated do you clean this ? The Housekeeping stated I will clean the , resident care director acknowledged that strong smell. Housekeeper took a commode to be clean. During interview conducted on at 10:13 AM with staff B she stated that " # , #39, #43, #52 have three beds because the residents are from Hospital Program they stay only for two - three months only.

During the facility tour on at 10:27 AM resident #13 in # stated "I want a little more privacy."

Observation during the facility tour on at 10:30 AM revealed that there was no curtain in # 's window.

During interview on at at 10:31 AM, Resident #14 reported that she moved into the a month ago, but the facility never put a curtain on her . She stated that she asked several times for them to put "something" there, but they never did. ."

Observation during the facility tour on at 10:37 AM revealed that there was no in # where Resident #15 resided.

During interview at 10:38 AM on with Resident #15, he stated "it has been that way for a while."

Class III

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

Based on observations and record review, Staff H did not follow the procedures outlined by the state while assisting 2 out of 17 sampled residents with self-administration of medication (#4 and #17).

Findings included:

On at 08:08 AM, Staff H was observed assisting Resident # 4 with medication. Staff H punched the medication out of a card: , 10 mg, , 81 mg, 10 mg, Hydrochlothiazide 25 mg, 850 mg, and , 50 mg . Staff H put them all in a cup, placed the cup in front of Resident #4, read the name of the medications listed on the medication observation record (MOR) to the resident, watch the resident swallow the medications, then wrote the initials of another staff's name on the MOR.

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On . . . . . at 9:10 A.M,. observed Staff H assisting Resident #17 with self-administration of medication 30 mg. The physician order it to be taken at 8:00 A.M. and , 25 mg at 7:00 A.M. Both medications were given more than one hour late.

Record review on . . . . . revealed that Staff H did not sign the MOR using her initials. Also, staff H started to assist with self-administration of medication at 7:51 AM while the medication time on the MOR stated 9:00 AM, and she signed for 9 AM.

Class III

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

Based on observation and record review, facility failed to have evidence of a negative . . . . . examination documented on an annual basis on file for 1 out of 11 staff sampled (Staff J).

Findings:

A review of Staff J's record revealed that she did not have documentation of a current negative . . . . . examination. The last test had been recorded on . . . . , and had expired on . . . .

During the exit interview on . . . . . at 12:46 pm, the administrator acknowledged that her test was expired.

Class III

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

Based on observation, record review, and interviews, the facility failed to ensure that three of 13 sampled staff met the training requirements pursuant to Section 429.52(5), F.S., prior to assuming the responsibility of Assisting with self-administration of medication .

Findings Include:

On observation of the staffing schedule revealed that there was one medication technician scheduled to cover the night shift, 11 PM- 7 am.

During Interview with Staff A on . . . . . at 12:25 PM, she stated that the facility ensured that there is a medication technician on all shifts. She further stated that the Certify nurse Assistance can as well

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assist with self- administration of medication.

During interview on at 5:34 AM Staff I stated "there is no med tech on the night shift, if someone needs a medication I call the supervisor to let her know and then I give the patient the medication and sign the book." She disclosed that she received the training for Assistance with Self-Administration of Medication.

Record review revealed that staff I, J, K did not have documentation of 4 hours initial training on file for assistance with self-administration of medication.

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 living environment for the residents.

Findings Include:

During the facility tour on at 09:44 AM, two boxes containing furniture, and one nightstand, were observed in the second floor hallway.

During interview conducted with Staff B at 10:17 AM, she stated "these have been here since a couple of days ago, they just need to put them in that need furniture."

During the facility tour on at 10:19 AM a broken armoire was observed in # ; at 10:23 AM the in # was observed to be broken (the wood is coming out on the top of the divider); at 10:24 AM a loose mirror was observed sitting on the top of a nightstand in # ; at 10:29 AM there was a strong odor of cigarette in # and #45; at 10:34 AM missing tiles observed in in the of # ; at 10:35 AM a strong odor of and a broken headboard noted in # ; at 10:37 AM a loose tile observed in the , at 10:43 AM a broken rail observed by # door; at 10:45 AM a broken dresser observed in # ; at 10:51 AM missing tile observed on the bottom of the in # . In # , the chest of drawers was missing one of the drawers. In # a resident was sitting on her bed mattress without bed linens and in # , a closet door was not attached.

Class III