STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911412	R 06/26/2017
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 Standard Biennial Survey revisit was conducted from , 2017 to , 2017. Livewell at Courtyard Plaza (license # 7169) with Limited Nursing Services and Limited Mental Health had deficiencies identify at the time of the survey:

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

Based on observation, interviews, and record review, the facility failed to provide care and services appropriate to meet the needs of 28 of 112 sampled residents (Residents #1-28).

Findings Included:

On at 9:53 A.M., observed Resident 21 at the entrance of 's door, in a plastic bottle behind a transparent patio chair. Staff A, who was present, acknowledged the incident. Staff A walked to # and called Staff M to assist Resident #21. Staff M arrived, held Resident 21's hands and stated "he is legally and he needs our assistance for everything." Observed that the resident was able to transfer with staff assistance inside # . Staff A sat Resident #21 in the wheelchair and stated "I will assist him with toileting." Staff A told Staff M that Resident #21 had a plastic bottle with in his jacket pocket.

Record review revealed that Resident #21's health assessment (AHA 1823 form) dated on had the following diagnoses: arm gunshot , shaft , and chronic confessional status with physical or sensory limitation " ." The resident needed help with activities of daily living (ADL's) showed independent with ambulation, dressing, eating, and toileting and transferring; needed supervision with bathing and assistance with self-care.

On at 10:00 A.M., observations of the common area by # and #18 had black substance (feces) in the toilet bowl and the shower. Staff A, acknowledged the findings and called a housekeeper to clean the 10:03 a.m. In # , Resident #20 was observed lying down in bed and stated "I need to go to the ." She repeated that several times consecutively. When asked if the resident could go on her own to the , the resident stated, "No I can't go by myself, I need help." Resident #20 was observed wearing an adult brief. Staff A instructed the housekeeper to clean the because Resident #20 needed to go to the . Staff A called a certified nursing assistant (CNA) to assist the resident.

A Review of Resident #20's health assessment (AHCA form 1823) dated showed the following diagnoses: ( ), , , , with physical or sensory limitations,

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wheelchairs , transfer with assistance and and as special precaution. Resident #20's needed assistance with all activities of daily living (ADL's).

On at 10:05 A.M., # had a strong smell. Staff A called the housekeeper and asked "did you clean this ?" The Housekeeper stated "I will clean the ." Staff A acknowledged that the strong smell. The Housekeeper took the commode and started cleaning it.

A review of the staffing schedule revealed that there were 3 staff (I, K, L) scheduled for the night shift.

On at 12:25 PM, staff A reported that the medication technicians are to assist the residents as well.

On at 4:40 A.M. staff did not respond while agency staff was at the facility's door. A staff person answered the emergency telephone number at 04:51 AM, then hung up.

On at 4:53AM observed through the glass window a resident walking in the hallway by the lobby area.

On at 04:56AM Staff I answered the emergency number and stated that she was all by herself with a patient on the second floor so we need to wait a minute for her to come open the door.

On at 04:58 A.M. Staff I opened the entrance door. She stated that there were two CNAs every night sometimes three. In # , observed Staff K and Staff J were assisting Resident #25. Staff I stated she had to go back on the second floor to her patient, who was in the .

On at 4:58 AM, Staff I reported that there were usually only two CNAs every night on the night shift. She stated that it just happened they have 3 CNA last night.

During an interview on at 5:10 A.M., Staff J stated "My shift is from 11:00 P.M. to 7:00 A.M. We are three CNAs today. We have more than 20 residents that need assistance with adult brief change, I don't know how many receiving hospice care. I don't know how many residents are here now, but there are a lot. Over a hundred residents. "

During an interview on at 5:14 A.M. Staff K stated "I don't know how many people are here.

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There are too many people. In case of emergency I don't know what to do. We evacuate them to the front desk because this is the only door that we can open. We do not have the code for the exit door to be opened."

On at 5:29 A.M., observed Staff K leaving the facility. She stated "My husband is sick. I told the administrator that I needed to leave early today. My job is done. I did what I was supposed to do." Observed when Staff K left that there were only two CNAs at the facility with a census of 112 residents.

On at 5:30 A.M. Staff J provided documentation of two hour round sheets on . The round sheet for 7:00 A.M. was completed by staff, one and a half hours prior to the time the rounds were scheduled to be done.

On at 5:34 A.M. Staff I acknowledged round sheet was completed before 7:00 A.M. She stated, "At 5:00 A.M when we prepare the residents for breakfast we complete the paper because we are only two persons and we do not have time to do the 7:00 A.M. rounds."

During interview conducted on at 05:34 AM, Staff I reported that there are more than 20 residents who need their briefs to be changed, and there are not enough staff on the night shift. She stated that "at least 4 CNA are needed, two on each floor and one on each side."

On at 07:20 AM Resident #16 was observed having difficulties walking with a walker to the dining . On at 07:37 AM, Resident #16 to the floor, landing on his back. There were no staff available in the dining help over 32 residents with activities of daily living. In the dining , Staff G and H were assisting residents with self-administration of medications.

A review of Resident # 16's health assessment (AHA 1823 form) dated showed the following diagnoses: with early and , . History of acute failure and rhabdomyolysis resolved and history (HX) of and ( )-controlled, or behavioral status" , ." The resident needed " Precautions." Resident #16's activities of daily living (ADLs) stated resident needed supervision with ambulation, bathing, dressing, toileting and transferring and he was independent with eating and self-care. On page #6 of the health assessment "Certificate of medical necessity" dated revealed that he needed assistance with activities of daily living, which is defined as individual assistance with ambulating, transferring, bathing, dressing, eating, and/or toileting , this documentation was signed by facility administrator, physician/physician assistant/ advance registered nurse practitioner/registered nurse. Subsequent documentation revealed that Resident #16 arrived to a Hospital on and for . Diagnoses and assessment of the day showed unspecified abnormalities of gait

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and mobility and unspecified with behavioral disturbance

Record review revealed seven staff (2 medication technicians and 5 CNAs) were scheduled to be working from 7 AM- 3 PM.

On at 07:49 AM Staff H reported to the paramedics "I was washing my hands when I heard the ."

During an interview on at 7:53 A.M., Resident #27 stated I'm living here since . She was observing the paramedic assisting Resident #16. Resident #27 stated "Look who ! He is my friend and we love him. He a few times with the walker. The walker is not safe for him, he needs a wheelchair and a person to assist him but no one is here."

During an interview on at 7:54 A.M., Resident #28 stated "Resident #16 a few times with the walker, he needs a person to assist him."

A review of Resident #23's revealed health assessment (AHCA 1823 form) dated showed diagnoses of High ( ), Dyslipidemia, and ( ). risk was noted as special precaution. The resident needed total care with ambulation, bathing, dressing, self-care, toileting and assistance with transferring. Furthermore, a progress note dated revealed that resident was hospitalized due to a .

Resident # 26 went to the hospital on . Record review of Resident #26's health assessment (AHCA form 1823) dated revealed the following diagnosis: ( ), ( ), ( ), ( ), , the resident had chest pain, "reported ." Had type 2, needed assistance with all ADLs and required administration of medications. A discharge summary and diagnoses dated revealed that the resident had " " resulting from a .

Hospital record review revealed Resident #26 was admitted at the hospital from to for a sacral . Resident #26 was an female with /Mental Health (pmh), ( ), ( ), ( ) and previous presented to emergency department (ED) following a at the assisting living facility (ALF) where she resides. She stated that she slipped down to the floor from the chair. On a physician spoke with another physician and both agreed that the patient should be able to go to rehab and be closely monitored. Her home medication was reconciled. Resident was placed on Norco as

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needed (prn) for the sacral , -Ct lumbar spine with contrast report impression multilevel degenerative change. Finding concerning for sacral . On discharge/care plan showed that patient and caregiver were informed about the patient diagnosis and conditions and the patient will be transferred for further care.

Class II

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interview and record review, the facility failed to file an adverse incident report for 1 of 28 sampled residents when Resident #26 and sustained a closed sacral requiring hospitalization.

Findings included:

A review of Resident# 26's record revealed that there was no comprehensive documentation in the file about a that had occurred in , requiring hospitalization.

Hospital record review for Resident #26's revealed that the resident was hospitalized from to , diagnosed with a sacral , closed. The admission diagnosis was with a sacral . The resident was transferred to a rehabilitation center.

On at 11:48 A.M., Staff A reviewed Resident #26's file and acknowledged that the resident was sent to the hospital because she at the facility. Staff A stated that from the hospital, Resident #26 was transferred to a rehabilitation center. She stated the resident was sitting with her legs up on a chair and but nothing happened to her, and that the facility did not file one day and 15 days incident reports.

A review of the Agency for Health Care Administration (AHCA) incident report database revealed that the facility didn't submit an initial or a 15 day adverse incident report regarding Resident #26's injury, which resulted in hospitalization.

Class III

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A review of Resident# 26's record revealed that there was no comprehensive documentation in the file about a that had occurred in , requiring hospitalization.

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A review of the Agency for Health Care Administration (AHCA) incident report database revealed that the facility didn't submit an initial or a 15 day adverse incident report regarding Resident #26's injury, which resulted in hospitalization.

Class III

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Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on observation, record review and interview, the facility failed to provide documentation of an eligible level II background screening in the personnel file for one out of eight sampled staff (K).

Findings include:

Staff K was observed in the facility on at 4:58 AM assisting residents in # . Staff K left the facility at 5:29 AM on .

A review of the employee file for Staff K (hired) showed documentation of a Level II Background Screening result dated . A review of the Background Screening Clearinghouse database showed Staff K's screening result was eligible on .

During an exit interview conducted on at 12:34 PM, Staff A acknowledged that Staff K's updated Level II background screening result was not in the file.

Unclassified