STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965386	08/17/2017
NAME OF PROVIDER OR SUPPLIER BOYNTON BEACH	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SOUTH CONGRESS AVENUE BOYNTON BEACH, FL 33426	

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

0000 - Initial Comments

An unannounced licensure Complaint survey, CCR #2017004869, was conducted on 11th, 15th and 17th, 2017 at Boynton Beach (License #9745). An allegation was substantiated. 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 review and interviews, the facility failed to ensure a new health assessment (AHCA Form 1823) was completed after a significant change occurred for 2 out of 2 sampled residents (Residents #1 and #2).

The findings included:

1. On at 1:00 PM, the Wellness Director stated during interview that Resident #1 had a current pressure .
Review of Resident #1's health assessment (AHCA Form 1823) dated revealed she had "no" pressure sores documented. During further review of Resident #1's record, the Service Notes showed the following:

a. Resident had an "open area noted left . Will fax order to MD (doctor) for HH (home health) evaluation and treatment".
b. "Re-faxed order request for HHC (home health care) to treat to left ".
c. "HHC nurse visited to provide care as ordered for open areas on left ".
d. "Left (protective bandage) dressing in place. Follow up by HHC nurse".
e. The next Service Note dated documented "Reviewed report from home health nurse that previously healed has re-opened. care restarted."

During another interview with the Wellness Director at 2:00 PM, she presented the home health agency notes she had obtained and acknowledged both of the pressure sores as noted were a significant change. No health assessments had been completed after the occurrence of the significant changes.

During interview with the Administrator at 3:00 PM, she acknowledged that the health assessments had not been completed as required for a significant change.

2. On at 1:00 PM, the Wellness Director stated during interview that Resident #2 had recently lost weight (unplanned weight loss/significant change).

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Review of Resident #2's health assessment (AHCA Form 1823) dated revealed the resident weighed 150 pounds at this time. The resident's record noted he had a weight loss from 146 pounds (2017) to 134 pounds (, 2017). This was identified as a significant change with the resident's HCP (Health Care Provider) and representative notified. However, a new health assessment was not completed at this time.

Additionally, the resident was admitted to hospice on or about . There was an incomplete health assessment found in the resident's file with no date of examination or hospice listed. During interview with the Wellness Director and Administrator at 2:30 PM on , they acknowledged that the assessment had not been completed but had been started due to the resident's significant change in condition (admission to hospice).

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 ensure a significant change for 2 out of 2 sampled residents (Residents #1 and #4) was documented; and, failed to ensure the resident's representative was notified of the significant change.

The findings included:

1. On at 1:00 PM, the Wellness Director stated during interview that Resident #1 had a current pressure .
Review of Resident #1's health assessment (AHCA Form 1823) dated revealed she had "no" pressure sores documented. During further review of Resident #1's record, the Service Notes showed the following:

a. Resident had an "open area noted left . Will fax order to MD (doctor) for HH (home health) evaluation and treatment".
b. "Re-faxed order request for HHC (home health care) to treat to left ".
c. "HHC nurse visited to provide care as ordered for open areas on left ".
d. "Left (protective bandage) dressing in place. Follow up by HHC nurse".
e. The next Service Note dated documented "Reviewed report from home health nurse that previously healed , has re-opened. care restarted."

During another interview with the Wellness Director at 2:00 PM, she presented the home health agency

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notes she had obtained and acknowledged both of the pressure sores as noted were a significant change. No additional documentation of the significant change, and subsequent notification to the resident's representative by the facility was found at this time in the resident's record. The facility was unable to show any form of notification was provided to Resident #1's representative regarding the pressure sores.

During interview with the resident's representative, he stated that neither the facility or the home health agency had notified him of the pressure sores.

When asked why the representative was not notified of the resident's significant changes, the Administrator responded by email on at 5:36 PM, "POA (Power of Attorney) is not activated-the resident has currently elected for her son to only be contacted in the event of an emergency". When asked for documentation showing the resident did not want her family contacted unless it was an emergency, the Administrator responded by email on at 9:42 AM, "Due to her (resident) not being deemed , , none of the advanced directives we have are "Active." To communicate freely with the son, would be a violation of HIPPA". A copy of the designation of the resident's son as her Health Care Surrogate was provided.

Review of the ARNP's (Advanced Registered Nurse Practitioner) notes dated , and revealed the following:
a. "Patient is a poor historian due patient's level of ".
b. "Alert and oriented x1".
c. " decline" listed as a diagnosis on .

There was no documentation in the resident's record to show the resident's status or resolution of the pressure after 30 days, following the onset on . There were no notes to show the continuous monitoring of the new pressure identified on . Additionally, there was no health assessment (AHCA Form 1823) done when the resident encountered either of the significant changes.

During interview with the Administrator at 3:00 PM, she acknowledged that the health assessments had not been completed as required for a significant change, and that the resident's representative had not been notified of the change. The Wellness Director stated at this time that the facility had not maintained documentation to show the continuous monitoring of the status of this resident's pressure .

2. During interview with the Administrator on at 2:00 PM, she stated Resident #4 was not a

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resident at the facility after the change of ownership occurred (2016), and the facility did not maintain the resident's record.

During interview with Staff A on at 1:15 PM, she stated the resident "started to not come down for breakfast, but still came down for lunch. I reported (the) to nurses when I changed his diaper and saw it. He had sometimes. He wouldn't sleep in his bed, only in the recliner. I don't know how long he had it (the on his)."

Review of the resident's record revealed the following health care provider orders:
a. "Unable to stand up for long".
b. "HH evaluation and treatment on area". cream to 3 times a day and PRN (as needed)".

The resident's health assessment (AHCA Form 1823) dated had "no" pressure sores documented. There were no subsequent health assessments available for review for this resident.

During interview with the resident's representative on at 12:45 PM, she stated that the resident was transported to the hospital after a on . She stated that the resident was admitted to the hospital "with a pressure ". She was not notified by the facility of any pressure sores, or of the resident's transport to the hospital. The resident remained a resident of the facility until 2017, but did not return (bed hold).

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on interviews and a record review, the facility failed to maintain a resident's record for a minimum of two (2) years following discharge for 1 out of 1 sampled residents (Resident #4).

The findings included:

During interview with the Administrator on at 2:00 PM, she stated Resident #4 was not a resident at the facility after the change of ownership occurred (2016), and the facility did not maintain the resident's record. She stated the resident's belongings were not removed from the facility until 2017, but that the resident did not physically return to the facility after the change of ownership. The Regional Operations Director also stated the resident's record had not been maintained.

During interview with Resident #4's representative on , she stated the resident had been

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transported to the hospital on , and was expected to return. She stated the monthly fees were paid to hold the resident's , and that the facility determined that the resident was not able to return on . She stated she picked up the resident's belongings on .

During review of resident records, there were none available for review for Resident #4. The facility provided no additional documentation for review at this time.

Class