STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911234	10/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA ON TURKEY CREEK	**2800 FORDHAM ROAD, NE PALM BAY, FL 32905**

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

0000 - Initial Comments

Relicensure survey including Limited Nursing Services (LNS) was conducted on and . Bethesda On Turkey Creek, License #4788, had deficiencies at the time of the visit.

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

Based on resident record review and interview, the facility failed to ensure that the Agency for Health Care Administration (AHCA) Form 1823 Health Assessment was completed entirely by the healthcare provider for 1 of 6 sampled residents (#2).

Findings:

Resident #2's AHCA Form 1823, dated , was missing documentation regarding the need for 24-hour nursing or care.

On at 2 PM, Resident Care Director confirmed the findings.

Class III

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

Based on record review and interview, the administrator failed to monitor the continued appropriateness of placement, and retained the resident who developed a which exceeded the continued residency criteria for 1 of 6 sampled residents (#3), did not obtain an admission hospice interdisciplinary care plan for 1 of 6 sampled residents (#8), did not obtain an updated Resident Health Assessment form (1823) for 2 of 6 sampled residents after a significant change for hospice admission and (#3 & 8).

Findings:

1. On at 10 AM, the Resident Care Director said resident #3 had an open on her and thought it was a . At 11:30 AM, the Resident Care Director said the resident was receiving care from an outside care doctor. She was requested to provide the notes from the care doctor by the agency.

Resident #3's record did not reveal any notes regarding the .

Review of the care notes provided by the facility revealed the following:

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- The visit summary noted "Non-Healing Left ." The measured 0.3 centimeters (cm.) x 0.3 cm. x 0.5 cm. to the .
- the visit summary noted "Non-Healing Left ." The measured 1.0 cm. x 0.2 cm. x 2.2 cm. at 3 O'Clock.
- the visit summary noted "Non-Healing Left ." The measured 1.0 cm. x 0.8 cm. x 0.5 cm. (undermining 3 O'Clock to 7 O'Clock position - 2.2 cm.)."

Further record review did not reveal any updated Agency for Health Care Administration (AHCA) health assessment 1823 form for the significant change.

On at 2 PM, the resident care director said she was not aware the resident had a . At 3:30 PM, the administrator said she was not aware the resident had a .

2. Resident #8's record revealed he was admitted to hospice services on . His record contained a health assessment form 1823, dated , and one dated . His record did not contain documented evidence to indicate a new 1823 was completed when he was admitted to hospice, as required.

Resident #8's record contained an interdisciplinary care plan between hospice and the facility, dated . There was no documented evidence to indicate a care plan was completed when he was admitted to hospice on , as required.

During an interview with the memory care coordinator on at 10:30 AM, she confirmed the findings.

Class III

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

Based on record reviews and interviews, the facility failed to follow health care provider orders for 5 of 6 sampled residents (#1, 2, 3, 8 & 13), failed to document when 1 of 6 sampled residents developed a , and failed to implement interventions to prevent the worsening of a for 1 of 6 residents (#3).

Findings:

1. Resident #8's record revealed a health care provider order dated to discontinue D.

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Review of resident #8' , 2017 Medication Observation Record (MOR) revealed D was signed as given from through .

During an interview with the memory care coordinator on at 2:44 PM, she confirmed the finding and said she forgot to discontinue the D entry on the MOR.

2. Resident #13 was identified as receiving Limited Nursing Services (LNS) for application of leg wraps.

On at 10:45 AM, resident #13 said staff helped her at night with her wraps because her legs were . She was only able to turn on the pump. Observations on at 11 AM, 2 PM and 3 PM noted she did not have leg wraps on.

Observations on at 9 AM, 12 PM and 1 PM noted she did not wear leg wraps and compression stockings.

On at 10 AM, the resident was in her . There were a set of lymphedema leg wraps on the floor near where she sat. She pointed to the wraps and said that was what she wore in bed at night.

Resident #13's health assessment form 1823, dated , listed the resident had high , and . " : The formation or presence of a clot in a ." (www.medicinenet.com).

A healthcare provider's order, dated , indicated wraps to both lower legs, on in the AM and off in the PM. Another healthcare provider's order dated indicated please use bandages daily but must start at toes and wrap up to knee. Healthcare provider's order, dated , indicated to apply " hose stocking to both lower legs and remove at night". " Hoses and Stockings are designed to help people with ...." (www.vitalitymedical.com).

Occupational , , note, dated , indicated caregivers good to follow through with compression wear and care to both lower legs. Occupational , , note, dated , indicated the resident was to wear the wraps twice a day and needed assistance of the facility staff too put on (wraps). A physician's verbal/change order, dated , indicated "Occupational , , to discontinue services. Pneumatic pump set at 25 milliliters of mercury (mm/hg) twice daily to both lower legs for 60 minutes. Resident and caregivers instructed."

Resident #13's record did not reveal a healthcare provider's order to discontinue the wraps or the compression stockings. There were no orders that instructed the facility nurses on the use of the

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pneumatic pump.

3. Resident #1 was identified as receiving LNS for leg wraps.

On at 9:30 AM, resident #1 sat in a wheel chair and wore a right ankle brace. Her right hand was contracted. The resident #1 stated that whomever staff helped her get dressed, put the brace on her. She had a larger leg brace that helped her walk but was not to use it anymore. It was under her bed.

Resident #1's health assessment, dated , indicated diagnoses of , osteopenia, and , right dormant side. She needed assistance with dressing, toileting, transfers and bathing, and with medications. An order, dated , was written for Arizona boots (brace). An order, dated , indicated Arizona boots to right leg daily. An order, dated , indicted to discontinue the right leg brace, and apply ankle wrap for prevention of twisting until Arizona is received.

Monthly doctor's visit on indicated the resident needed an Arizona ankle foot for custom ankle support due to right ankle instability, right sided , and difficulty transferring .

The LNS notes, dated to , documented the application and removal of the right ankle brace. The note dated during the 3-11 shift indicated the right leg brace was removed by the doctor, and a new order was for a right ankle wrap, on in AM off in PM.

The LNS notes did not reveal any evidence to confirm healthcare provider's orders were obtained for the application of the ankle brace or the discontinued use of the leg wrap. There were no notes that documented the process taken to ensure the timely delivery of the Arizona brace .

On at 10 AM, the nursing director stated the resident went to a doctor's appointment and returned without the brace, because her doctor did not want her no wear thee leg brace any more.

On at 11 AM, the resident was accompanied by the nursing director in her a physical . She wore a right ankle brace. The and resident stated that the resident's son brought the brace.

4. On at 10 AM, the Resident Care Director said resident #3 had an open on her , and thought it was a .

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Resident #3's record did not reveal any facility notes regarding when the , developed and the care that the facility would be responsible to provide. There was no documentation to confirm that the health care provider and the family were aware the resident had an , .

On at 11:30 AM, the Resident Care Director said the resident was receiving care from an outside care doctor. She was requested to provide the notes from the care doctor by the agency. Review of the care notes provided by the facility revealed the following:
- The visit summary noted "Non-Healing Left ." The measured 0.3 centimeters (cm.)x 0.3 cm. x 0.5 cm to the .
- the visit summary noted "Non-Healing Left ," The measured 1.0 cm. x 0.2 cm. x 2.2 cm. at 3 O'Clock.
- the visit summary noted "Non-Healing Left ," The measured 1.0 cm. x 0.8 cm. x 0.5 cm. (undermining 3 O'Clock to 7 O'Clock position - 2.2 cm.).

On at 2 PM, the resident care director said she was not aware the resident had a , . At 3:30 PM, the administrator said she was not aware the resident had a , .

On at 2:05 PM, resident #3 sat in her wheelchair and confirmed she had a , on her . She was asked what was she doing to relieve the pressure. She said she would lift up on one side as she demonstrated how she did it.

There were no facility notes that documented the healing progress of the resident's and the proactive interventions that were in place to prevent the from worsening.

On at 10 AM, the resident care director said she found out the resident was receiving home health care for the . She was asked to provide the home health notes. The notes were not provided until the end of the survey on .

The home health notes revealed a record report that noted on , a to the left was noted as an "abscess" that measured "0.5 cm. x 0.5 cm. x 0.01 cm. Cleansed with cleaner, applied barrier to periwound as needed to prevent maceration and protect periwound, covered with Aquacel Ag and foam dressing. Secure with Tegaderm. changed dressing." The next note was not until and read, "cleansed with cleanser, patted dry, applied silver dressing, covered with border dressing, skin barrier to periwound...."

Further treatments were noted on , , , , , , , ,

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, , , and was the last treatment noted by home health. The following measurements were noted: and - 0.4 cm. x 0.4 cm. x 0.01 cm.; - 0.3 cm. x 0.3 cm. x 0.5 cm.; - 1.4 cm. x 1 cm. x 1 cm.; and - 0.7 cm. x 0.7 cm. x 1 cm. The report noted the episode ended on . There were no other treatments from the home health agency noted after .
The report noted that on at 9:27 AM, the home health agency received an order from the care doctor for the "nurse to cleanse the left with cleanser, , dry, apply skin barrier to periwound, Pack with silver foam cut in strips leaving tail exposed, cover with gauze, border dressing and Suresite dressing, frequency twice a week until healed or new orders received." The care report noted the onset date was , the next visit was and noted "Up , LT Abscess." Visit date (day of survey). Measurements were 1.5 cm. x 0.7 cm. x 0.2 cm.

On , the home health agency's clinical nurse said she would have to look through records to determine all of the treatments received by the resident. She said there was a new order and the nurse visited on . Additional home health agency notes on were requested to determine if treatment was received from through . The home health notes were not provided

The resident care director and the administrator were not aware the resident had a , , and the facility had nothing in place to prevent the , that had developed from worsening. According to the home health notes obtained the last treatment was on , and there was no other treatment until the resident's care doctors note on .

Resident #3's health care provider's order, dated , for a sliding scale for coverage revealed the following: Flex Pen fasting sugar 3 times a day before meals - 150-200 = 2 units, 201-250 = 4 units
251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, and over 400 = 12 units.

Resident #3's Medication Observation Record for indicated the same documentation as the above order at 7 AM, 11 AM and 4 PM. The nurse documented on at 11 AM the Sugar result as 182 - 2 units of was required; the nurse noted "0" in the space for amount given. On at 11 AM, the nurse documented the Sugar result as 235 - 4 units of was required and 6 were given. On at 10 AM, the resident care director reviewed the MOR and confirmed the incorrect amount of was noted by the nurse as given.

5. On at 10 AM, resident #2 said she did not like the caregivers coming in the middle of the night or early morning at about 3 or 4 AM to give her medicine for pain. She stated that she did not like

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this time because they have to wake her up from her sleep. She liked taking the medication at the time she had before going to bed every night at 10 PM.

Resident #2's physician's order, dated , indicated an order for a , 5-325 milligrams (mg.) changed dose routine to be taken at 8 AM, 2 PM, and 10 PM, and another physician's order, dated , for at 8 AM, 2 PM and 8 PM.

On at 9:30 AM, the Resident Care Director, also a Licensed Practical Nurse (LPN), reviewed the physician's orders, and stated that the family member requested that the medication times be changed to round the clock at 8 AM, 2 PM, 8 PM, 2 AM and that the facility was honoring family's request. Not only were the times changed but also the frequency from three times a day to four times a day. The Resident Care Director confirmed there was no documentation that the physician was notified of the change and increase in the resident's medication frequency from three times a day to four times a day.

On at 11 AM, a telephone call to a family member to verify the request of medication time change was attempted but unsuccessful, so a voicemail message was left to return the call.

Class II

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

Based on the resident's rights, facility's procedures and interview, the facility failed to honor recognition or respect personal dignity in responding to residents' complaints during the monthly menu food chat of the dining experience for reviewed months , 2017, 2017, and , 2017.

Findings:

Residents complaints about he food menus for past three months were reviewed.

On , , 2017, resident complaints were: Food comes out sometimes; healthier meal options again.

On , 2017, residents complaints were: Food comes out sometimes; tacos are too spicy; too much cornbread; too much spinach; repetitive snacks; residents want various flavors of coffee creamers.

On , 2017, residents complaints were: too much Tilapia; repetitive meals; food comes out

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sometimes; pizza is like cardboard, want fresh pizza or pizza from another source; same salad dressings, want more options.

On at 11:30 AM, the administrator stated she did not have any documentation of resolution for the complaints of all the food menu chats for previous months reviewed, but beginning , 2017, a new menu was going to be approved by the registered dietician and implemented with residents' food requests.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview, the facility failed to maintain accurate Medication Observation Records (MORs) for 1 of 6 sampled residents (#4).

Findings:

Resident #4's , 2017 MOR listed 50 milligrams (mg.) at bedtime, and was marked as "OOF" from to . All of the other resident's medications had a line (-) on and . There were no notations on the back page of the MOR or in the resident's record that explained what "OOF" and a line meant.

On at 10 AM, the nursing director stated "OOF" and the line meant the resident was out of facility, and went home with family during hurricane Irma. There were no written notations maintained regarding the resident's absence during those days.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and interview, the facility failed to follow the healthcare provider's order for a drug for 1 of 6 sampled residents (#2) as prescribed.

Findings:

On at 10 AM, resident #2 said she did not like the caregivers coming in the middle of the night or early morning at about 3 or 4 AM to give her medicine for pain. She further stated that she did not like this time because they have to wake her up from her sleep. She liked taking the medication at the time she had before going to bed every night at 10 PM.

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Resident #2's physician's order, dated . . . . . , indicated a . . . . . , ... 5-325 milligrams (mg.) changed dose routine from 8 AM, 2 PM, and 10 PM, to another physician's order, dated , to be given at 8 AM, 2 PM, and 8 PM.

On . . . . at 9:30 AM, the Resident Care Director, whom was also a Licensed Practical Nurse (LPN), reviewed the physician's orders, and stated that the family member requested that the medication times be changed to round the clock at 8 AM, 2 PM, 8 PM, 2 AM and that the facility was honoring the family's request. Furthermore, it was requested if there was evidence or documentation verifying that the healthcare provider was notified of the family's request for change medication times and she confirmed no documentation that the physician was notified. Not only were the times changed but also the frequency from three times a day to four times a day.

On . . . . at 11 AM, a telephone call to a family member to verify the request of medication time change was attempted but unsuccessful, so a voicemail message was left to return the call.

Class III

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

Based on observations and interviews, the facility was not maintained to promote a home-like atmosphere free from offensive odors.

Findings:

During the facility tour on . . . at approximately 11 AM, there was a odor in resident #3's . . . . Upon opening the door to the , there was a very strong, pungent and offensive odor that made it difficult to breathe.

On . . . . at 2 PM, the administrator confirmed the finding.

Class III

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

Based on record review and interview, the facility failed to record the admission weight for 1 of 6 sampled residents (#3) and Medication Observation Records (MORs) for 3 of 6 sampled residents (#3, 4 & 8).

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Findings:

Resident #3's record revealed she was admitted to the facility on but there was no admission weight available for review. On at 12:15 PM, the administrator said the admission weight could not be located.

On at 9 AM, the MORs for through were requested for residents #3, 8 and #4.

On at 9:30 AM, the administrator said the MORs were pack in boxes and she would have to go through the boxes to locate the request MORs. The MORs were never provided for review.

Class III

0167 - Resident Contracts - 58A-5.025 FAC

Based on record review and interview, the facility failed to have a documented provision regarding a written claim against a refund providing notification to the resident or responsible party at least 14 calendar days for 1 of 2 sampled residents (#2).

Findings:

Resident #2's contract agreement dated revealed that it did not have a documented provision regarding a written claim against a refund providing notification to the resident or responsible party at least 14 calendar days.

On at 11 AM, the administrator confirmed the finding.

Class

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on the review of the facility's Emergency Plan and interview the facility failed to submit a plan for review and approval to the local emergency management agency when there were substantial changes.

Findings:

The last emergency plan approval letter, dated , reflected the facility submitted it to Brevard County Office of Emergency Management. However, an annual emergency management plan was not submitted when the management company took over the day to day operation of the facility.

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Review the renewal application submitted to the Agency on revealed the management company took over day to day operation of the faciltiy on . Further review of the renewal application revealed the administrative date of hire ws .

On at 12:30 PM, the administrator confirmed the above findings and stated she submitted an emergency plan for approval on .

Class III