STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953207	01/31/2018
NAME OF PROVIDER OR SUPPLIER **FOUNTAINVIEW**	STREET ADDRESS, CITY, STATE, ZIP CODE **145 EXECUTIVE CENTER DRIVE** **WEST PALM BEACH, FL 33401**	

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

0000 - Initial Comments

An unannounced relicensure survey was conducted on and at Fountainview Assisted Living facility, License #7827. The facility had deficiencies at the time of the 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 ensure an updated Health Assessment (AHCA Form 1823) was completed for 2 of 2 sampled residents (Residents #1 & #6).

The findings included:

1) Record review revealed Resident #1's latest Resident Health Assessment (AHCA Form 1823) dated listed Resident's #1 diagnosis of , , High , , , , , , , , (, ,), , , , , , , OSA (Sleep ,), (,) and Spinal .

Review of the resident's demographics sheet revealed that she was also diagnosed with .

Review of Resident #1's MOR revealed that the resident is currently taking ER 500 mg (a Medication) one time a day.

During an interview with the Resident Services Director ( ) on at 1:59 PM, she confirmed that Resident #1's Health Assessment (1823) was the latest available and did not reflect all current diagnosis. No further documentation was provided.

2) Record review revealed Resident #6's latest Health Assessment documented on AHCA Form 1823, dated listed under the Nursing/ Treatment and , , Service Requirements that Resident #6 only currently requires assistance with medication.

During an observation on , Resident # 6's Physical , was observed standing at the resident's door. The Physical , advised the that the resident is doing a lot better. The stated Resident #6 is currently receiving Physical , , .

During an interview with the Home Health Nurse on at 2:35 PM she confirmed that Resident #6 is currently receiving Physical , , services from a contracted , , service located within the facility.

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During an interview with the on at 2:04 PM, she confirmed that Resident #6's Health Assessment (1823) was the latest available and did not reflect all current services. No further documentation was provided.

Class III

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

Based on record review and interview, the facility failed to follow the continued residency requirements for 1 out of 14 sampled residents (Resident #6).

The findings include:

Record review revealed Resident #6 was admitted to the facility on . Review of Resident #6's AHCA Health Assessment 1823 form dated in section "A" ADL's (Activities of Daily Living) revealed Resident #6 requires total care with bathing, dressing, self-care ( ) and toileting.

Further record review of Resident #6 also revealed that Resident #6 received a score of 38 on the level of care assessment program completed by the nursing staff at the facility on . Further review of the assessment revealed the Care level ranged from 1-4; a score of 38 placed Resident #6 in a care level of 3. According to the assessment Resident #6 was dependent on staff for the entire bathing activity and required staff monitoring for more than once a day.

Interview with Staff F on at 1:27 PM revealed that Resident #6 is totally dependent upon direct care staff to be dressed, bathed, toileted and . Staff F stated that she also conduct assessments and is familiar with Resident #6. Staff F confirmed the Resident 1823 reflecting total for 4 ADL's.

Interview with Staff A on at 10:01 AM revealed the resident always needs someone around to prevent and he is considered a risk.

Interview with Resident #6's Home Health Nurse on at 2:35 PM revealed the resident is dependent with ADL's such as bathing and toileting. The Home Health Nurse also stated that Resident#6 is very fragile and weak.

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Class III

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

Based on interview and observation, it was determined the facility failed to honor resident rights for 1 of 1 sampled residents (Resident #6) regarding the use of full bed rails and continence care.

The findings include:

On [redacted] at 10:11 AM during an interview with Resident #6 it was revealed that he was very unhappy about residing within the facility. The resident stated that his unhappiness stemmed from having full bed rails, he felt as if he was being confined to the bed at all times during the night. The resident stated he has asked to be educated on how to use them, but the staff refuses to teach him. The resident then advised direct care staff that if he can't operate them himself then he does not want them on his bed. The resident stated he has complained about having the bedrails on his bed and everyone ignores him. The resident further stated when the direct care staff is in his [redacted] he ask them for help they ignore him, and don't assist him.

During further interview, Resident #6 reported that he asked the direct care staff on the overnight shift to take him to the [redacted] (date unknown) and the staff member replied to him stating "Just pee on yourself and I will come up and change you"; Resident #6 explained to the staff member that he did not want to pee on himself that he wants to use to the little independence he has left. Resident #6 stated that many times he has pressed the button for direct care staff to come and take him to the [redacted] he stated at times it can take them up to an hour to come up to his [redacted]; he stated "I cant hold my [redacted] for an hour." The resident stated the response time to the call bell is extremely slow and there is no point in having the system in place. He reported on one occasion when direct care staff did come to his [redacted] take him to the [redacted], he asked the staff member to assist him in pulling up his pants and the staff member replied, "Why don't you pull it up yourself since you want to be so independent". The resident stated this is how they get their revenge on me because they know I will [redacted] and hurt myself. During this interview Resident #6 exhibited no signs of [redacted], was alert and oriented and answered all questions and concerns appropriately.

On [redacted] at 10:46 AM an interview was conducted with Staff F and Staff H regarding Resident #6's bed rails. Staff F advised that there is a doctor's order in his file stating that he is allowed to have bed rails on his bed and he currently has a hospital bed for mobility. Staff F also advised that even though it is against the facility policy to have full bed rails they allowed him to reside in the facility with them since

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his admission from rehab on . Staff F stated they are currently trying to locate a manufacturer that makes " " that are compatible with his bed.

On at 3:40 PM Staff F called the resident's physician and made a telephone request to change the full bed rails to ½ bed rails. The physician approved the order and the full bed rails were removed and replaced with ½ bed rails.

On at 3:45 PM, the Administrator was informed about concerns regarding Resident #6. The Administrator stated to the surveyors that Resident #6 is usually mild and docile and doesn't complain about anything. He further stated "were going to order labs on him and see what's going on with him".

On at 3:50 PM an interview was conducted with Staff F regarding the comments stated by the Administrator about Resident #6. Staff F explained that when a resident is acting different, it is the facility's protocol to order labs to see if the Resident has a ( ) or if there is medical issue that needs to be addressed. She further explained that its uncommon for Resident #6 to all of a sudden state the concerns that was reported in an earlier interview.

On at 11:59 AM a confidential interview was conducted in regards to the care and services that Resident #6 is currently receiving. The interviewee was afraid of retaliation and did not want to make it known to the facility what the concerns were. It was stated that Resident #6 was not being treated very well at the facility because staff members choose to ignore him. It was stated that it was witnessed first-hand that Resident #6 would ask a question and they would do the minimum, which included changing his clothes, putting him in the bed and then leave his addressing or even acknowledging his questions. It was stated the facility had sent notification about purchasing bed rails that are allowed in the facility but they were too expensive and could not be purchased. It was stated to management (unknown date) that Resident #6 was very unhappy about the bed rails and asked if any other options of bed rails were available other than full bed rails; the facility informed the interviewer that no other bedrails would be able to fit the resident bed. The interviewee confirmed all of the concerns stated by Resident #6.

Class III