STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968951	**02/09/2018**
NAME OF PROVIDER OR SUPPLIER **ARTIS SENIOR LIVING OF BOCA RATON LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **5910 N FEDERAL HWY** **BOCA RATON, FL 33487**	

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

0000 - Initial Comments

An unannounced Complaint Survey, CCR #2017011789 was conducted on , 2018, , 29, 2018 and , 2018 at Artis Senior Living of Boca Raton, a 64 bed ALF facility, License #12835. The facility had deficiencies at the time of the visit.

0028 - Resident Care - Activities of Daily Living - 58A-5.0182(4) FAC

Based on observation, record review, and interview, the facility failed to ensure the supervision of Activities of Daily Living (ADLs) for one (Resident #1) of three residents reviewed. Specifically, the facility failed to meet the care and services to meet the needs for toileting and incontinence care. Resident #1's 1823 (Health Assessment) states that the resident required total assistance with ADLS.

Findings Include:

During review of the Resident #1's record on , the Resident's 1823 Health Assessment states in the ADL section, the resident required total assistance with toileting: "For wiping & cleanliness 4x day and changing pull-ups."

On at 3:00 PM the surveyor telephoned Employee #3, who stated she was with Resident #1 on the morning of the alleged incident. "All I know is that this woman was doing fine. I had to run around and do menus and I told her to stay and I would be back. She couldn't make it down to the her own. It was about 9:30, 10:00 AM. I don't know what happened. They said that she went back to her . But that's hard to believe. She had her faculties, no one knows what happened. Normally they had to walk Resident #1 to the , to the .

On at 3:53 PM the Surveyor made a telephone call to Employee #5. This Surveyor asked if he was at the facility that day. He stated: "Yes I was there." Surveyor asked who notified him of the incident. He said that the Director of Health and Wellness did. I asked where the alleged incident took place, and he stated it happened in her . "If you contact the hospital, you'll see in the report that she had a , that's what led to her ."

Surveyor asked if Resident #1 was accompanied to her anyone. Employee #5 stated that "I wouldn't say that she went by herself; would it be more appropriate to say that residents can walk throughout the community alone ..." Surveyor asked again if someone was with her when she went to her . Employee #5 responded: "No, she went to her herself."

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I asked Employee #5 if he knew if someone was with her in the / the time of the incident. He stated "Not at the time." This Surveyor asked Employee #5 when she was discovered. He responded: "When we were doing our hourly check. She was seen about 10 minutes before in the Activities Section."

Surveyor asked Employee #5 what he would say was the time between her and the arrival of the ambulance. He stated "The care partner stayed with her, she performed First Aid, and stayed till the ambulance arrived. Surveyor asked who the Care Partner was. The information was provided; "but she is no longer part of the community."

Additionally, facility Nurses Notes were reviewed and documented on at 11:20 AM: "Resident (#1) was observed lying on the floor in her apartment in the BR. Resident had a full breakfast, attended activities and returned to her rest before lunch. She was observed @ 11am in bed resting. 11:20am upon entering her , the care partner observed her lying on the BR floor, she had obvious injuries ...."

The Resident's 1823 stated that the resident required total supervision/assistance with toileting "For wiping & cleanliness 4x day & changing pull-ups," During conversation with Employee #5, it was stated that Resident #1 was not accompanied by anyone. Additionally, she was not assisted with toileting, as is required by the 1823 Health Assessment.

Class III

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

Based on observation, record review, and interview, the facility failed to provide the Medication Observation Records (MORs) for 1 of 3 residents reviewed. During review of Resident #1 facility records, the Surveyor observed that the Medication Observation Records (MORs) for Resident #1 was not in the file.

Findings Include:

During review of Resident #1's records on between 2:18 PM - 3:30 PM, it was observed that the resident's MORs was not in the resident file. During review, Employee #6 came into the Surveyor was working. Employee #6 was asked by this surveyor if she had the progress notes for the files requested, along with any related documents. Employee #6 stated that she had the health records and went to get them. In the interim, Employee #4 came in and asked if anything was needed.

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Employee #6 stated she was going to get the Health charts for the files and said that she didn't "think Resident #1 was part of the community." Employee #4 confirmed that she is no longer part of the community and they didn't have any files on her.

At 2:24PM, Employee #6 brought the (health) charts in. Resident #1 file wasn't with them. Employee #6 had left the . . surveyor noticed such. A review of the files provided was conducted.

At 3:15PM, the Surveyor asked Employee #4 again about progress or nurses notes for Resident #1. She stated that she had to "check with (another employee), "she may know. But I think, because there was a claim on her already. I don't know."

At 3:26PM, Employee #4 brought the Health file for Resident #1 into the . . this surveyor was working. "This is what you're looking for." Surveyor reviewed file and observed the Medication Observation Records (MOR's) that were in the file. During review, it was observed that there were no MORs for 2017 in the file. They were from through 2016.

Also, the Nurse's Notes in the file records: : "Resident cognition return to baseline. 2PM after 40 min w ER. Full ROM to . . . . . extremities as per report from ER nurse. Daughter notified."

Lastly, this Surveyor requested copies of the Hospital notes from the facility providing the emergency care. On surveyor received copies on the report. A review of the report was conducted with a Health Quality Assurance (HQA) Field Office Nurse supervisor. Review of the report was not able to determine the cause of the alleged incident.

As the alleged incident occurred during the time covered by the missing MORs, surveyor was unable to determine what medications were given to the resident on the day of the alleged incident.

Class III

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 submit a State Adverse Incident report to the State Agency following an incident, for 1 of 3 sampled residents (Resident #1).

Findings included:

Resident #1 had an incident on . . . . . in which she was found on the floor in the . . . . . .

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transferred to the hospital to receive a higher level of care.

On a complaint survey was conducted at the facility. During an interview with Employee #4, the surveyor requested to see any incident reports completed by the facility. The employee stated the facility does not have any incident reports.

Employee #4 informed the surveyor the facility does not keep or have an Incident Log. Regarding incidents that have/or may occur at the facility, Employee #4 stated that the information would be documented in the resident's chart.

On a review of the Agency for Health Care Administration's Adverse Incident Reporting system was conducted. The review revealed that no report was submitted regarding Resident #1's incident through the system as required.

Class III