STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911749	R 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESERVE AT PALM AIRE (THE)	**3701 MCNAB ROAD POMPANO BEACH, FL 33069**

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

0000 - Initial Comments

An unannounced revisit to the Limited Nursing Services (LNS) survey was conducted on . . . . . at Preserve at Palm Aire (the), License #7693. The facility had an uncorrected deficiency (N276) and one new deficiency (A0031) identified at the time of the visit.

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC

Based on observation, interview and record review the Assisted Living Facility (ALF) failed to ensure communication was maintained between a Home Health Agency (HHA) and the ALF for 1 of 1 sampled residents reviewed receiving HHA services, (Resident #2), as evidenced by the failure to communicate the status of wounds for Resident #2.

The findings included:

On at 10:40 AM, during a facility tour accompanied by the Resident Care Coordinator, Resident #2 was observed being wheeled past with an observation made of a dressing to his left area. An inquiry was made to the Resident Care Coordinator regarding who was providing care for the resident to which she replied a HHA nurse comes in to do it.

Review of the clinical record revealed Resident #2 moved into the ALF on . . . . . Review of the Resident Assessment 1823 completed by the physician dated , revealed no documentation of any wounds. Further review of the clinical record revealed no physician orders for home health services for care.

Review of the admission Resident Notes dated , the Licensed Practical Nurse (LPN) documented the resident to have 'wounds on left leg and foot cover with dressing'. There was no further documentation of the status of the wounds in the resident's record.

On at 11:55 PM an interview was conducted with LPN Staff 'A' inquiring about the dressing on Resident #2's left leg. LPN Staff 'A' stated that is being done by the home health nurse. A request was made to review the physician order for home health and care to which LPN Staff 'A' stated the order would be in the chart. LPN Staff 'A' reviewed the resident's record and concurred there was no physician order for home health or care. LPN Staff 'A' then further stated it is probably in the home health chart. Review of the home health chart Care Coordination Notes revealed the HHA Registered Nurse (RN) conducted the start of care on with documentation of a to the left area and left lateral foot. There was no documentation of the frequency of the . . . care or

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the treatment modality. The next entry by the HHA RN is dated documenting care rendered to the left foot and left knee with in brackets (New) and left leg area resolved.

Review of the Resident Notes dated document ' care done by home health nurse at 5:30 PM.' There is no further documentation related to what body part the care was rendered or if the home health nurse communicated the status of the (s) or a new area of concern was identified to the left knee.

On at 12:00 PM a request was made to LPN Staff 'B' to provide the order for home health services for care for Resident #2. LPN Staff 'B' stated she will call the home health nurse to see where she got the order to provide care.

On at 12:05 PM LPN Staff 'B' stated she spoke with the home health nurse and the home health nurse stated she received the order for care from the hospital. LPN Staff 'B' could not elaborate, stating the home health nurse is on her way to the nursing station.

On at 12:10 PM, the Director of the Memory Care unit arrived to the nursing station with an order for care for Resident #2 dated . She stated the order just did not make it to the chart as yet. An inquiry was made to the Director of the Memory Care unit if the physician order is not in the resident record how would the ALF nurses know what care treatment was ordered in case the home health nurse was not available, to which she replied she guessed they would have to call the doctor. Review of the physician order produced, documented care to be rendered daily to a forehead laceration and to the right 4th toe digit, in addition to care to to the left and right lower legs and left foot every Tuesday, Thursday and Saturday. Review again of the home health RN documentation in the Care Coordination Notes dated , was a Monday, with no further documentation of care rendered as of , a Friday.

On at 12:20 PM an interview was conducted with the home health RN who stated she was the one that changed the care frequency from Tuesday, Thursday and Saturday to Monday, Wednesday and Friday. An inquiry was made why her last documentation is on , a Monday, with no notes for , a Wednesday, to which she stated she has not written that note as yet. An inquiry was made where she was documenting the daily care to the resident's forehead and right 4th toe digit to which she stated those wounds have healed, however there was no documentation in either the home health chart or the ALF record. A further inquiry was made to the home health RN regarding the new to the resident's left knee to which she stated the resident sustained the transferring from the bed to the chair. An inquiry was made what care treatment she was providing to this new to which she stated the same as the other 2 wounds. A request was made to the home

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health RN to produce the physician order for the care to the new to which she stated she called the physician and is using the same treatment however was not able to produce a physician order for the additional care. The home health RN was not able to state she alerted the ALF staff of the new . A further inquiry was made to the home health RN if the ALF nurses wanted to see what was happening with the wounds would they have to track her down to which she replied "Yes Mame."

On at 12:29 PM an interview was conducted with the Director of the Memory Care unit apprising her of the new the home health RN identified on to which she stated surprisingly, 'if there is a new why was that not reported?'

On at 1:00 PM, during the exit conference, the Director of the Memory Care unit concurred the status of the needs to be documented and if there is a new that should have been reported to the ALF staff.

Review of the ALF Documentation Requirements for Third Party Providers states in part, 'All disciplines to sign in for each visit in the (name of home health agency) ALF Red Binder on the daily Communication Log; Copy of all orders to go in ALF chart; All disciplines to check in with ALF/Memory Care nurse on duty - weekly the status of to be reported to ALF manager.'

Class III

N276 - LNS - Nursing Services - 58A-5.031(1) FAC

Based on observation, interview and record review the Assisted Living Facility (ALF) failed to include a resident using hose (antiembolic stockings) on the Limited Nursing Services (LNS) Log to ensure the appropriate assessment and monitoring of the hose for 1 of 1 sampled residents identified as requiring the use of the hose, (Resident #1), as evidenced by failing to assess and monitor the use of hose for Resident #1.

The findings included:

Upon entrance to the facility on at approximately 10:10 AM, a request was made to the Director of Memory Care to provide a list of residents receiving LNS services. The Director of Memory Care stated she does not think there are any residents receiving LNS services at this time but will obtain the LNS Log to make sure.

On at approximately 10:30 AM, the Director of Memory Care provided the LNS Log, stating

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there are no residents on LNS at this time. A review of the Log was conducted and no residents were listed as receiving LNS services. An inquiry was made if there are any residents who have hose applied, to which she stated she thinks there might be one resident.

On at approximately 10:40 AM, the Director of Memory Care produced a Medication Observation Record (MOR) for Resident #1, stating he has the stockings applied around 11:00 AM and they are removed at night. An inquiry was made who applies the stockings to which she replied, 'the nurses.'

On at 10:50 AM, during a facility tour accompanied by the Resident Care Coordinator, an interview was conducted with Resident #1 inquiring about the use of the antiembolic stockings. Resident #1 stated he has in both legs that is why he uses the stockings. He stated they get put on around 11:15 AM and are removed around 7:00 PM. An inquiry was made who assists him with the application of the stockings, to which he replied 'different people, employees around here, and looking at the Resident Care Coordinator he stated the aide (name of staff member) who has worked here for a long time, will put the stockings on for him'. The Resident Care Coordinator confirmed the name of the staff member was an aide and not a licensed nurse. Additionally, Resident #1 stated he discovered a new hose with zippers instead of pull on and the Director of Nursing (DON) has ordered them for him and they should arrive in a couple of days.

Review of the resident's clinical record revealed a copy of a History & Physical assessment from a hospital visit for Resident #1 dated documenting 'He currently is reporting he has in his legs, the left more so than the right.' Further, the physician documented the resident had recently been treated for a right (,) (a clot). Further review of the clinical record MOR revealed Resident #1 is on an oral medication daily.

Review of a physician order dated documents 'Patient to have knee high support stockings, facility to place on patient (both legs) in large, on AM off at bedtime.' The physician order does not include the length of time the hose are to be worn to be beneficial for the leg . Additionally, there was no evidence the physician was notified of the zippered hose that were ordered to replace the traditional hose to see if the physician was in agreement with the use of the alternate type of hose to determine if they would be beneficial or not for his , needs.

Review of the clinical record revealed a pharmacy fax request order from the DON, dated , 3 days after the physician order, to send large compression stockings for Resident #1.

Review of the 2018 MOR revealed the order for the ' hose knee high leg put on every

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morning and remove at night', with staff initialing the On and Off blocks starting on , when the hose were ordered by the physician on . Further review revealed no times the hose were applied or removed. Further review of the MOR revealed on , and the medication was held indicating the levels were above therapeutic range which could make the resident at a higher risk for and . On the dose of the medication was reduced from 5 mg daily to 4 mg daily.

Review of the Resident Notes revealed no nursing documentation about the application of the hose in the morning and removal at night; no assessment or monitoring of the hose; no documentation of the status of the resident's legs that were the indication for the use of the hose.

On at 12:25 PM an interview was conducted with Resident #1 inquiring if the hose had been applied yet today, to which he stated a brand new employee put them on stating he was told it was her first day on the job. Resident #1 was not certain if she was a nurse or an aide.

On at 12:30 PM an inquiry was made to the Director of Memory Care who the new employee was. It was determined the new employee who started today was a Licensed Practical Nurse (LPN) Staff 'C'.

On at 12:32 PM the 'new' LPN was interviewed who confirmed she applied Resident #1's hose on around 11:30 AM. An inquiry was made how Resident #1's legs looked to which she replied both legs were edematous ( ) with the left more than the right.
Review of the 2018 MOR revealed the LPN initialed applying the hose on , time not documented.

Review of the Resident Notes revealed no documentation the hose were applied or the status of Resident #1's legs. There was no baseline status documentation to determine if the was worse or better.

Review of the LNS Log Limited Nursing Services policy guidelines states in part, services to include 'Assisting, applying, caring for and monitoring the application of anti- stockings or hosiery as prescribed by the health care provider.'

On at 1:15 PM the exit conference was held with the Director of Memory Care concurred Resident #1 qualified to be under LNS in addition concurred if the resident is on a there is a higher risk of which should be monitored when wearing compression stockings. This is an uncorrected deficiency.

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