STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965812	**04/25/2018**
NAME OF PROVIDER OR SUPPLIER **B P ASSISTED LIVING FACILITY II**	STREET ADDRESS, CITY, STATE, ZIP CODE **1174 WYNNEWOOD DR** **WEST PALM BEACH, FL 33417**	

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

0000 - Initial Comments

A licensure complaint survey (CCR#CCR# 2018005573) was conducted from to at Assisted Living Facility II, license #10137. The B P Asissted Living Facility II had deficiencies identified at the time of the survey.

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

Based on observation, record review and interview, the facility failed to provide continuous daily observation and failed to have awareness for the health, safety and well-being of 5 out of 5 residents (residents #1, 2, 3, 4 and 5). This resulted in all the facility residents being placed at risk, without being able to evacuate the facility in the event of an emergency and in one resident (resident #1) to become entrapped while unsupervised.

The findings included:

In an observation on from 6:00am to 6:15am, there was no answer at the front door of the facility after knocking continuously on the front door. In an observation on at 6:09am, a car drove past the front of the facility and this car parked approximately one street north of the facility. In an interview with the law enforcement detective on at 6:10am, she stated that she saw an individual jump out of this parked car and run towards an adjacent home's backyard. She stated at this time that she was not able to identify this individual since it was dark and there was limited visibility. In an observation on at 6:15am, the administrator opened the front door of the facility and stated that he was asleep immediately before opening the facility's front door.

On at 6:16am, upon entering the facility observation revealed resident #1 in her adjustable hospital-style bed. The head and foot of the bed were both raised to the highest position with the half side rails up. The resident was sitting on the side of her bed with her legs hanging off the side of the bed. Resident #1 was entrapped from her abdomen area to her lower extremities between the bed's surface and the side rail. During this observation, the resident stated she was attempting to transfer out of the bed to answer the door, but she was unable to move out of her position due being entrapped between the side rails and the bed. . The resident presented to be in considerable distress while she attempted moving out of her entrapped position.

In an interview with resident #1 on at 6:16am, she stated that she was stuck between the bed and the side rail and could not transfer in or out of bed. She said she attempting to go answer the knock at the front door.

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In an interview with the administrator on at 6:20am, he stated that he was designated to provide continuous care and supervision and to maintain awareness for the health, safety and well-being of all the 5 residents presently living in the facility. He stated that resident #1's condition had recently declined and the resident relied on the staff's physical assistance to ambulate and transfer in and out of bed safely. He stated that residents #2, 3, 4 and 5 also required certain levels of assistance and supervision from the staff and resident #5 needed total assistance because she presently received hospice care due to having a diagnosis.

In a follow-up interview with the administrator on at 6:30am, he confirmed that he departed the facility on or about 5:30am that morning so he could go to a friend's home to pick up some clothing. He stated that when he left the facility property that morning for about 45 minutes, there were no other staff members present to provide continuous direct care or supervision to any of the five residents that resided in the facility. He stated that during this period of absence from the facility, the residents were not being observed, did not receive any oversight or personal care and he was not aware of their personal health safety and well-being.

Review of resident #1's record indicated that she was admitted to the facility on and her most recent health assessment dated on indicated that she was diagnosed with , muscle , tremors and . Review of this health assessment indicated that the resident needed supervision with ambulation, transfers, dressing and toileting, she needed assistance with bathing and , and she needed assistance with self-administration of medications. Review of this health assessment indicated that the resident required universal precautions and she required care and supervision in the assisted living facility in order for her needs to be met.

Review of resident #2's health assessment dated on indicated that he was diagnosed with post , right leg amputation, and was forgetful. Further review of this health assessment indicated that the resident required daily assistance with his self-administration of medications and the resident required care and supervision in the assisted living facility in order for his needs to be met.

Review of resident #3's health assessment dated on indicated that she was diagnosed with and . Further review of this health assessment indicated that the resident required to receive daily assistance and supervision with ambulation, bathing, dressing, eating, and toileting, and the resident required care and supervision in the assisted living facility in order for her needs to be met.

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Review of resident #4's health assessment dated on indicated that he was diagnosed with with left , and . Further review of this health assessment indicated that the resident required to receive daily assistance with his self-administration of medications and the resident required care and supervision in the assisted living facility in order for his needs to be met.

Review of resident #5's health assessment dated on indicated that she was diagnosed with , , dyslipidemia and required hospice services. Review of this health assessment indicated that the resident required assistance with all of her activities of daily living and the resident required care and supervision in the assisted living facility in order for her needs to be met.

In an interview with resident #5's private duty aide on at 10:20am, she stated that resident #5 received hospice care in the facility because the resident was 100% dependent on the staff to assist the resident with all of her activities of daily living. She stated that resident #5 required additional personal assistance beyond what the facility could offer, and this was the reason why the resident's representative hired her to assist the resident 7 hours per day, 7 days per week. She stated that her schedule required her to be at the facility from 9am to 7pm every day, including an extended lunch period in the afternoon. She stated that residents #1, 3 and 5 were since they were physically dependent and had some

In an interview with the nurse practitioner on at 5:00pm, he stated that he was familiar with all the residents that lived in the facility and they all required care and supervision in an assisted living facility so they can receive personal care services from the staff. He stated that residents #1 and 5 were due to their compromised physical and mental conditions, and resident #1's condition recently declined considerably.

Class I

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

Based on observation, record review and interview, the facility failed to provide the right to live in a safe environment free from and neglect for leaving 5 out of 5 residents (residents #1, 2, 3, 4 and 5) without continuous direct care and supervision from its staff and for physically restraining 1 out of 5 residents (residents #1). Specifically, the administrator left all facility residents unattended and unsupervised for an unknown period of time, which resulted in one resident (resident #1) to become

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entrapped between the bed and the side rail.

The findings are:

In an observation on from 6:00am to 6:15am, there was no answer at the front door of the facility after knocking continuously on the front door. In an observation on at 6:09am, a car drove past the front of the facility and this car parked approximately one street north of the facility. In an interview with the law enforcement detective on at 6:10am, she stated that she saw an individual jump out of this parked car and run towards an adjacent home's backyard. She stated at this time that she was not able to identify this individual since it was dark and there was limited visibility. In an observation on at 6:15am, the administrator opened the front door of the facility and stated that he was asleep immediately before opening the facility's front door.

On at 6:16am, upon entering the facility observation revealed resident #1 in her adjustable hospital-style bed. The head and foot of the bed were both raised to the highest position with the half side rails up. The resident was sitting on the side of her bed with her legs hanging off the side of the bed. Resident #1 was entrapped from her abdomen area to her lower extremities between the bed's surface and the side rail. During this observation, the resident stated she was attempting to transfer out of the bed to answer the door, but she was unable to move out of her position due being entrapped between the side rails and the bed. . The resident presented to be in considerable distress while she attempted moving out of her entrapped position.

In an interview with the administrator on at 6:20am, he stated that he was scheduled to care for the facility residents from 7pm to 7am that night and morning, and that he was not aware of resident #1's positioning requirements, which would prevent her from potentially injuring or restraining herself. He claimed to not know how the residents bed had gotten into this position. He stated that the resident's condition had recently declined and the resident relied on the staff's physical assistance to ambulate and transfer in and out of bed safely. In an observation on at 6:20am, the administrator had to retract the side rail and lower the head of the bed so he could safely reposition resident #1 while she was sitting on the side of the bed.

In an interview with the administrator on at 6:30am, when asked why he was observed entering the facility through the neighbor's back yard and the facility's back door earlier that morning and he stated that he departed the facility on or about 5:30am that morning so he could go to a friend's home to pick up some clothing. He stated that when he left the facility property that morning for about 45 minutes, there were no other staff members present to provide continuous direct care or supervision to any of the five residents that resided in the facility. He stated that during this period of absence from the

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facility, the residents were not being observed, did not receive any oversight or personal care and he was not aware of their personal health safety and well-being.

Review of the facility 2018 work schedule indicated that the administrator was scheduled to work every day from 7pm to 7am and no other staff member was scheduled to work any of the overnight shifts this month.

Review of resident #1's record indicated that she was admitted to the facility on . Resident 1's most recent health assessment dated on indicated that she was diagnosed with , , muscle , tremors and . Review of this health assessment indicated that the resident needed supervision with ambulation, transfers, dressing and toileting, she needed assistance with bathing and , and she needed assistance with self-administration of medications. Review of this health assessment indicated that the resident required universal precautions and she required care and supervision from the assisted living facility in order for her needs to be met. Further review of the resident's record did not contain a physicians order or statement for the resident's safe use of the adjustable bed and its side rails.

In an interview with the manager on at 6:45am, she stated that she was usually scheduled to work from 7am to 7pm, while the administrator worked the 7pm to 7am shifts. She stated that she relied on the administrator to work the overnight shifts in the facility since the residents required continuous 24-hour oversight and personal care, and all of the residents required some kind of assistance from staff in the event of an emergency. She stated that she was not aware that resident #1 did not have a physician's order or statement for the resident's use of the adjustable bed and its side rails.

In a follow up interview with the administrator on at 8:00am, he confirmed that he drove passed the facility on at 6:10am to park about one north from the facility. He stated that after he parked his vehicle that morning, he then rushed into the facility by going through his neighbor's backyard and jumped over the fence into the facility's backyard. He stated that once he was in the facility backyard, he snuck into the facility through the doorway on the north end of the facility, and went through the laundry the hallway so he could answer the knock at the front door.

Review of resident #2's health assessment dated on indicated that he was diagnosed with post , right leg amputation, , and was forgetful. Further review of this health assessment indicated that the resident required daily assistance with his self-administration of medications and the resident required care and supervision in the assisted living facility in order for his needs to be met.

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Review of resident #3's health assessment dated on indicated that she was diagnosed with , , , and , . Further review of this health assessment indicated that the resident required daily assistance and supervision with ambulation, bathing, dressing, eating, and toileting, and the resident required care and supervision in the assisted living facility in order for her needs to be met.

Review of resident #4's health assessment dated on indicated that he was diagnosed with with left , and . Further review of this health assessment indicated that the resident required daily assistance with his self-administration of medications and the resident required care and supervision in the assisted living facility in order for his needs to be met.

Review of resident #5's health assessment dated on indicated that she was diagnosed with , , , , dyslipidemia and required hospice services. Review of this health assessment indicated that the resident required assistance with all of her activities of daily living and the resident required care and supervision in the assisted living facility in order for her needs to be met.

In an interview with resident #5's private duty aide on at 10:20am, she stated that she was hired privately by resident #5's representative to care for the resident 7 hours per day, 7 days per week. She stated that residents # 5 and #1 occupied the same she observed resident #1 being tied to the bed with a bedsheet on at about 6pm. The resident remained on the bed tied in the same position until she returned to the facility in the morning of . (Photographic evidence obtained). She stated that on at about 5:30pm, she decided to untie resident #1 from her bed because the resident appeared to be in distress and her stated were hurting. She stated that the manager was working in the facility on and and that the manager was aware that resident #1 was restrained to the bed and did not immediately untie the resident. She stated that the manager likely preferred for the resident to remain restrained so the manager would not have to continually provide care and supervision to the resident and to not meet this resident's immediate needs. She stated that the manager was aware that she untied resident #1 from the bed on at approximately 5:30pm and the manager immediately took the resident to the the resident needed to go to the toilet. She stated that the manager also previously tied resident #1 on the dining to restrain and keep the resident from transferring out of the chair. She stated that she was aware of the photographs that the Agency received with this complaint and those photographs were taken while resident #1 was restrained to the bed on .

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Review of the facility , 2018 work schedule indicated that the manager was scheduled to work every Saturday and Sunday in , from 7am to 7pm, including on and .

In an interview with the nurse practitioner on at 5:00pm, he stated that he was familiar with resident #1's medical care and he ordered 2 half-bed rails on to be used on the resident's bed to prevent her from rolling out of bed while sleeping. He stated that he did not perform a written medical review for the resident's continued safe use of the bed side rails after . He stated that the resident declined with her physical function during the past year and the resident needed assistance with ambulation, transfers, toileting and most of her activities of daily living. He stated that the resident was a high risk for and was very unstable while walking. He stated that he recommended for the HOB to be raised at 30 to 45-degrees maximum while the resident was resting on the bed and the lower half of the bed to be flat, since it was not needed for the resident's feet to be elevated. He stated that if the HOB and the lower half of the bed were both raised to their highest levels or near the highest levels, and the half-side rails were raised, it would place the resident at risk for being restrained and entrapment/injury because she required physical assistance to transfer in and out of the bed.

Class I