STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953207	**05/31/2018**
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 operation Spot Check Monitoring survey was conducted on and at Fountainview, License #7827. The facility had deficiencies identified during the survey.

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

Based on record review and interview, the facility failed to adequately supervise the health care for 1 out 6 residents (Resident #1), which was ordered to receive physical services by the physician on the resident's health assessment. The facility failed to offer supervision and monitoring of a resident that required continous and failed to ensure timely reorder of the supply, for 1 out of 6 sampled residents (Resident #3).

Findings included:

In an interview on at 12:30 PM, Resident #1 stated that he has recently a couple of times and he had to go to the hospital after one of his . He stated that he received a letter from his health insurance provider, approving him to receive physical servies, but the facility has not arranged for him to receive any physical services yet.

Review of Resident #1's record indicated that his health assessment (AHCA form 1823) completed on , 2017 he was diagnosed with , , major , aneurism, , chronic kideney , left eye and unsteady gait. Further review of this health assessment indicated that the resident was at risk, had balance issues and needed help with is activities of daily living and physical services.

Review of resident #1's review completed on revealed that Resident #1 was a risk, and had a history of within the last six months. This review also revealed that the resident has an unsteady gait, ambulates with the assistance of another person, had balance and transfer , was considered high risk, and that appropriate interventions should be implemented. Further review of this assessment indicated that the facility did not document any steps to prevent any future resident . Review of the resident's level of care program review completed on revealed that the resident received level of care 2 that included indivudal care and services to be provided by the facility staff.

A review of resident #1's nurse progress notes on , 2018, indicated that the resident suffered a

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, and received a to neck, and to left arm. Review of the resident's nurse progress notes on , , 2018, the resident suffered a and was found kneeling by his bed and unable to get up on his own. Review of the resident's nurse progress notes on , , 2018, the resident suffered a and was found lying on the floor with a laceration the left side of his head, left side of eye, and left side of elbow. These notes indicated that the resident got , and , and was transported to the hospital after this . These notes indicated that the resident returned to the facility later that same day and no new interventions to prevent a or accident risk were documented to be implemented in the resident's care.

A review of the facilities internal nurse progress notes reads that on , , 2018 at 8:30PM, Facility contacted the residents' son and informed him that his father was assessed by One Home for physical , , , and that the physician orders for the physical , , will be received in the morning.

Interview on at 1:50pm, the Director of Nursing (DON) revealed that Resident #1 was offered physical , on numerous occasions and refused each time. The Director of Nursing (DON) acknowledged that she was unable to provide any proof of the numerous occasions where the resident denied physical , . The Director of Nursing (DON), stated that she was unaware that the resident received a letter from his health care insurance approving physical , , . The Director of Nursing (DON) stated that she failed to follow-up and ensure that the resident received the correct level of care in regards to the physical , , , ordered by the doctor and internal reports written up by the facility staff. The Director of Nursing (DON) stated that there are policies in place for precautions, especially because the resident was deemed a high risk.

A review of the facilities internal Risk Program Policy revealed that the community can utilize a system of visual identifiers to allow staff to maintain awareness of risk , such as falling stars, falling leaves, colored dots or colored wrist . The procedure reads as: The executive director and /Wellness Director will review all resident within 24-72 hours to evaluate the circumstances and probable cause(s) for the at that time. The will then modify and/or implement a service plan to minimize the risk of repeat , and the resident will be monitored post every 15 minutes x4.

Interview on at 2:20pm, the Director of Nursing (DON) revealed that the facility does not follow that procedure, and the policy differs from each location. The Director of Nursing (DON), was unable to produce a policy in place for that specific location. The Director of Nursing (DON) stated that there is a resident service flowsheet, which gets signed off at the end of each work shift, and upon the completion of various resident related task. The Director of Nursing (DON) explained that the facility had no way to keep track that the residents that were risk were actually being observed during the duration of each work shift. The Director of Nursing (DON), was not able to provide records that a

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member from One Home Health came to see the resident on , nor any physician orders.

b) Upon entering Resident #3's , surveyors could hear the concentrator runing in the residents , however, the resident did not have the in use for herself (tubing not present on residents face). During an interview with Resident #3 on at 11 AM, it was revealed that the resident is on continous . Further observation of the resident's the tubing and hose for the was wrapped around the resident's bed. Further interview with Resident #3 revealed she was confined to her the last two days due to lack of portable . She stated she had ran out and that the facility was in charge of reordering the . During an interview with the floor nurse in charge, at this time, she retrieved the and placed on the residents face upon surveyor intervention. The floor nurse revealed that she had order portable for the resident on before the weekend. She was asked if she had followed-up on the order and/or the weekend staff and provide proof that it was order. However, she was unable to provide any documentation indicating the facility had made any efforts to obtain the . During an interview with the Administrator and DON on , it was revealed that the floor nurse should have ensured that the resident had a supply of portable before she had ran out. The facility was also unable to provide any documentation notifying the doctor and/or request for additional portable for the resident since she was an extremely active resident to prevent her from being confined to the . The facility was also asked if they had a policy for ensuring the timely refill of , they informed the survey that no policy existed. The DON returned around 1 PM, and informed the surveyors that she had contacted the supply company and that the would be delivered today within the next two hours, if not sooner.

Review of Resident#3's health assessment confirmed that she required continous . This information was discussed with the DON and that it was the facility responsibility to ensure that the is readily available for the resident and that the facility monitors the resident use of the . The DON also stated that staff should be montioring the resident's use of during , including reminding the resident to use the and determering when the supply has ran low to ensure sufficient time to reorder.

Class III

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

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Based on observation and interview, the facility failed to ensure that all portable was safely stored in the resident's 3 of 4 sampled residents (Resident's 1, 3, 5).

The Findings Included:

On between the hours of 10:00AM and 12:PM, during the observational tour, # was observed and revealed 1 large tank not properly stored in a holder, and lying on the floor. Further review of # revealed a large tank not properly stored in a holder and lying on the ground. In # there were 3 small tanks not stored properly in a holder and sitting on the floor.

During a interview with the Director of Nursing, she acknowledged the findings.

Class III

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

Based on record review and interview, the facility failed to submit a Comprehensive Emergency Management Plan (CEMP) for review and approval.

The Findings included:

On at approximately 1:00PM, an attempt was made to review the facility's current CEMP approval. The Administrator provided an approved Fire Inspection dated , 2017 indicating the CEMP had been reviewed by the Bureau of Fire Prevention. However, the Administrator was unable to provide a current approved CEMP from the local emergency managment agency, nor was he able to provide a submittal receipt.

During an interview with the Administrator on at approximately 1:00PM, he acknowledged the findings and provided no additional documentation for review.

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