STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968683	06/20/2018
NAME OF PROVIDER OR SUPPLIER **BANYAN PLACE**	STREET ADDRESS, CITY, STATE, ZIP CODE **2950 NW 5TH AVENUE** **BOCA RATON, FL 33431**	

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

0000 - Initial Comments

An unannounced relicensure survey was conducted on - at Banyan Place, License # 12548. The facility had deficiencies at the time of the visit.

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

Based on record review and interview, the facility failed to ensure that a updated Agency for Health Care Administration Health Assessment (AHCA Form 1823) was completed after a resident exhibited a significant health change (including behavioral status, elopements, nursing services, etc), for 1 of 4 sampled residents (Resident#16 & #19).

The Findings Included:

On at approximately 12:30PM, a resident record review was completed for Resident#16 and revealed, Resident#16 was admitted to the facility on . A review of the AHCA 1823 Form dated revealed a medical history of: Valve Replacement, of Nasal Tremor, Type 2 Retention, without behavior disturbance. Further review revealed Resident#16 receives with all activities of daily living, except eating which he requires supervision to cut up his food. The AHCA 1823 Form documents Resident#16 as alert and oriented with periods of forgetfulness.

On at 12:45PM, a review of Resident#16's progress reports documented on revealed Resident#16 was sent to the hospital due to difficulty to arouse and a sugar of 392. On the resident was returned to the facility on with a a discharge diagnosis of and . The resident returned to the facility with a Mid Line (-) in his upper right arm, and home health was ordered to infuse Caftriavone daily for 10 days. Upon return from the hospital no new AHCA Form 1823 was completed to reflect the significant change. Further review of home health records revealed Resident#16's line was discontinued on .

During an interview on at approximately 3:20PM with the Administrator and Assistant Administrator, they acknowledged the findings and provided no additional documentation for review.

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b) On at 04:55 PM, a confidential source indicated Resident # 19 lacks capacity to make informed decisions. The source stated that Resident #19 has . The confidential source indicated the staff is always looking for Resident # 19, as he had gotten lost several times and wandered away from the facility. The confidential source stated the last time the Resident had wandered onto the main street and was returned by the police.

On at 10:00 AM, a tour was conducted with the Assistant Administrator. He identified Building B as appropriate for the more independent residents with little . He identified Building A, as the building for residents who may require more assistance and have , cognition. Both buildings have open access for entry and exit. The facility does not have a secure Memory Care Unit. The Residents were observed walking back and forth between buildings, unsupervised. An attempt to interview 5 residents in Building A, found them not interviewable based on their cognition level, including Resident # 19.

Review of Resident #19's file revealed an admission date of . The AHCA 1823 form dated , stated Resident # 19 suffered from a history of , with a triple Bi-pass. The 1823 form also stated that the Resident's care or behavioral status shows he suffers memory loss, and is to place and time, which places him at a great safety risk if he has eloped the facility and walked out onto the busy 2 lane road in front of the facility. Further review of the filed lacked evident of a picture for facility staff and Law Enforcement to identify and locate him. Observations of Resident #19 revealed he did not wear any identifier on him, to make it easier for the Law Enforcement to return him to the proper location. The AHCA 1823 form indicated the Resident requires supervision with self care , dressing and toileting. He also needs assistance with bathing. This assessment indicates he is adult requiring assistance with his Activities of Daily Living, (ADL's). The Resident is able to ambulate independently making it easier to become an elopement risk.

On this same day a review of the Nursing Communication sheet was reviewed. The note dated at 10:00 AM stated Resident # 19 was moved from Building B, which is appropriate for higher functioning Independent Residents to Building A, where the residents requiring a higher level of care and suffer from . No additional details documented to indicate the reason for the move.

On a review of the Nursing Communication Sheet, dated at 02:15 PM was conducted. It revealed that Resident # 19 could not be located by facility staff. They checked the building, but was unable to locate the resident. The note stated the Resident was returned by a police officer within 30 minutes. No further information found in record regarding the incident. The record revealed that the last AHCA form 1823 was updated on after Resident # 19 was moved to

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the new building. The updated AHCA 1823 form based on the resident recent significant behavior changes failed to illustrate/determine if further safety measures or additional supervisory care was required.

On an interview was conducted with the facility Administrator and Assistant Administrator, both acknowledged the findings.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on interview and record review, the facility failed to ensure that all staff received the required in-service training within 30 days of employements, for 1 out of 4 sampled sample (Staff B).

The findings included:

Review of Staff B's file (hire date of) revealed no documentation indicating completion of the following training; Facility emergency procedures, including chain-of-command and staff relating to emergency evacuation. The requirement indicates this training should be completed within 30-days of hire. The facility had exceeded the 30-day requirement to train Staff B on Emergency evacuation, as it is currently Hurricane season and this procedure may be required to be performed soon.

On an interview was conducted with the Administrator and the Assistant Administrator; they acknowledged the findings.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation, interview and record review, the facility failed to maintain a 3-day emergency food supply of non-perishable food, based on the census of the facility. The facility also failed to maintain adequate water required for drinking and food preparation. The facility failed to provide a plan to obtain additional water in an emergency for all residents of the facility,

The findings included:

On at 03:00 PM, a tour of the facility kitchen was conducted with the Assistant Administrator. It was revealed that the facility does not maintain a 3-day emergency food supply for emergencies. The

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food storage area only contained food for day-to-day preparation.

On a review of the 3-day emergency food supply inventory sheet revealed that the facility Dietitian had issued a 3-Day Disaster Food and Paper Inventory Per Levels list. The inventory list provided for quantities for the following food categories: Beverages, Soups, Protein, Vegetables, Fruits, Grains and Puddings. The inventory list calls for the facility to maintain 144 gallons of water. The inventory list calls for 400 Paper plates, bowels, cups, plastic knives, forks, spoons and paper napkins. These items were not available.

On at 03:27 PM, an interview was conducted with the Administrator and the Assistant Administrator. They confirmed that they did not maintain a separate 3-day emergency food supply because they have a large generator to supply the kitchen with power. The Assistant Administrator stated he was not aware of the requirement.

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 complete an Adverse Incident Report (1 day & 15 day) to notify the licensing agency of an elopement, for 1 of 4 sampled resident records reviewed (Resident # 19).

The findings included:

On at 04:55 PM, a confidential source indicated Resident # 19 lacks capacity to make informed decisions. The source stated that Resident #19 has . The confidential source indicated the staff is always looking for Resident # 19, as he had gotten lost several times and wandered away from the facility. The confidential source stated the last time the Resident had wandered onto the main street and was returned by the police.

On at 10:00 AM, a tour was conducted with the Assistant Administrator. He identified Building B as appropriate for the more independent residents with little , . He identified Building A, as the building for residents who may require more assistance and have , cognition. Both buildings have open access for entry and exit. The facility does not have a secure Memory Care Unit. The Residents were observed walking back and forth between buildings, unsupervised. An attempt to interview 5 residents in Building A, found them not interviewable based on their cognition level, including Resident # 19.

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Review of Resident #19's file revealed an admission date of . The AHCA 1823 form dated , stated Resident # 19 suffered from a history of , with a triple Bi-pass. The 1823 form also stated that the Resident's care or behavioral status shows he suffers memory loss, and is to place and time, which places him at a great safety risk if he has eloped the facility and walked out onto the busy 2 lane road in front of the facility. Further review of the filed lacked evident of a picture for facility staff and Law Enforcement to identify and locate him. Observations of Resident #19 revealed he did not wear any identifier on him, to make it easier for the Law Enforcement to return him to the proper location. The AHCA 1823 form indicated the Resident requires supervision with self care , dressing and toileting. He also needs assistance with bathing. This assessment indicates he is adult requiring assistance with his Activities of Daily Living, (ADL's). The Resident is able to ambulate independently making it easier to become an elopement risk.

On this same day a review of the Nursing Communication sheet was reviewed. The note dated at 10:00 AM stated Resident # 19 was moved from Building B, which is appropriate for higher functioning Independent Residents to Building A, where the residents requiring a higher level of care and suffer from . No additional details documented to indicate the reason for the move.

On a review of the Nursing Communication Sheet, dated at 02:15 PM was conducted. It revealed that Resident # 19 could not be located by facility staff. They checked the building, but was unable to locate the resident. The note stated the Resident was returned by a police officer within 30 minutes. No further information found in record regarding the incident.

On a review of the facility policy on Elopement, entitled Elopement/Missing Resident Policy and Procedure. It was determined that the facility failed to follow their own policy which states the following should be conducted.
4. Notification of the resident's family/responsible person is to be accomplished by the administrative person in charge.
5. An incident report is to be completed by the staff member in charge.
6. The Administrator will complete and submit the required one (1) day and fifteen (15) day report.

On an interview was conducted with the facility Administrator and Assistant Administrator. The Administrator stated they did not notify AHCA, due to the fact that they did not call Law Enforcement. He stated Law Enforcement returned him to the facility. He was advised that the requirement was not met, as Law Enforcement was involved in the incident. He acknowledged the findings

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Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on record review and interview, the facility failed to ensure that all resident contracts contained a provision stating at least a 30 day written notice will be given before any rate increase for 2 of 4 sampled residents (Residents#16 & Resident#19).

The Findings Included:

On at approximately 1:30PM a review of Resident#16's contract agreement revealed, the resident was admitted to the facility on . . . . Further review of the signed contract revealed there was no written provision in the contract that stated the resident would be given a 30 day written notice before any rate increases.

During an interview on . . . . . at approximately 3:20PM with the Administrator and the assistant Administrator, they acknowledged the findings and provided no additional documentation for review.

Class III