STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965503	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDENTIAL PLACE	**3880 SOUTH CIRCLE DRIVE HOLLYWOOD, FL 33021**

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR# 2018004866, #2018005201 and #2018005212 were conducted on - at Presidential Place Assisted Living Facility, License #9921 . The facility had deficiencies identifiead at the time of the survey.

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

Based on observation, interview and record review, it was determined that the facility failed to provide personal supervision as appropriate for each resident , for 1 of 3 sampled residents (Resident # 1).

The findings included:

Review of Resident # 1's file revealed an admission date of . Resident # 1 suffers from Parkinson's , Type II , Compression of first Lumbar and vision.

On at 10:00 AM, an interview was conducted with the Administrator. She stated she recalled the event on involving Resident # 1. She says the resident was calling the staff for 2 hours and no one answered the pendant call button. She stated she called the front desk and no one answered. She stated the resident called 911 and Fire Rescue and Law Enforcement came to the facility. She says when the police came to the facility, they could not locate the staff. She says the police called the Maintenance Director. He walked the building with the police. In the Memory Care I unit, he found 1 staff wrapped in a blanket asleep on the sofa. This was the staff member assigned to Resident # 1. When the police woke her up, her eyes were red as if she had been asleep for a long time. The Maintenance Director and law Enforcement only found one staff member awake. The Administrator stated she implemented a corrective action plan for this incident. She terminated all staff asleep on this shift, with the exception of one staff member. She hired a new team for the 11:00 PM -7:00 AM staff. (Agency staff). The facility purchased new radios and pagers for the staff. The facility hired 24-hour concierge staff to answer the pendants after they go unanswered for 10 minutes. The concierge staff works: 6:00 AM. - 2:00 PM., 2:00 PM - 10:00 PM and 10:00 PM - 6:00 AM.

The Administrator further stated that she provided an in-service training to all staff on regarding supervision and the facility policy. The training stated the Staff are to review their assignments and/check pager and answer calls within 5 - 10 minutes. Pull need to be hanging and not wrapped around. According to the Administrator this policy was already in policy and that staff should be awake their entire shift to ensure supervision, care and services are provided to all residents on a regular basis and as needed.

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On at 10:30 AM, an interview was conducted with the facility Maintenance Director. He confirmed that Law Enforcement called him to come to the facility. He stated the police indicated that they had called the Administrator and the Health and Wellness Director, but could not get an answer. He confirmed that the statement made by the Administrator was accurate.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on interview and record review, it was determined the facility failed to accurately assess a resident as an elopement risk to ensure adequate supervision was provided at all times, for 1 of 3 sampled residents' files reviewed (Resident # 5).

The findings included:

Review of Resident #5's file revealed an admission date of . Review of Health Assessment documents that the Resident #5 suffers from , Memory trouble . Her physical or sensory/limitations indicates slow, guarded gait and . Resident #5's or behavioral status shows poor reading comprehension. The Nursing/treatment/ service requirements are documented as watching for precautions/needs help and has/ . Special precautions noted as looking for her cat at the neighbor's house, as she is a wanderer. She is independent with eating, toileting, transferring and requires assistance with bathing. She requires supervision with ambulation, dressing, self-care and toileting.

Review of the facility's internal investigation for the elopement incident on regarding Resident #5 revealed the following. The door alarm in Memory Care I sounded. The Staff performed a head count; Resident # 5 was not in her apartment or in the community. The resident was located on {street name} by police; the location the Resident was found was a busy 4-lane main road. The Resident was unable to state what happened, as she is . She was returned by local Police. The Resident was assessed by the Director of Nursing (DON).

On a review of the resident observation notes was conducted. The notes dated stated the following: I received a call from the night Supervisor at 05:15 AM, indicating the alarm was going off in Memory Care unit I. Resident # 5 was noted missing. 911 was notified as per Elopement protocol. A complete building and parameter check was completed. Resident # 5 was located on {street name] by the main street. The Physician and Responsible Party and State notified by the Manager on duty. The Staff was made aware of the elopement and Resident # 5 was to be monitored closely.

A review of the elopement risk tool in the Resident's chart was conducted. On the score was 0, which indicated the resident has no behaviors associated with memory . The facility failed to review Resident #5's Health Assessment form (AHCA 1823 form) dated , which stated the Resident has a history of wandering to her former neighbor's home to locate her cat. On the risk tool indicated that Resident # 5 goes for walks and has to be redirected to the entrance of the building or back to the property.

A review of the Individualized Service Plan for Resident #5 dated was conducted. The Plan documented the following: Time/Place: Oriented but occasionally forgetful. Some , difficulty in remembering simple details, may need prompting and orienting or 2 wrong on memory test. Wandering: Wanders in public spaces within the secured unit, but does not wander into other's apartments.

Resident #5 was a adult that was residing in the secured Memory Care I unit. Therefore, the facility was expected to provide supervision to this resident at all times to ensure the safety and well-being of the resident. The resident was placed in the Memory Care unit due to her memory and as noted on the Health Assessment and based on her history. The facility's internal elopement assessment tool was not accurately completed which should have also identified the resident as an elopement risk allowing the facility to implement the elopement policy and procedure regarding supervision of this resident. The facility failure to properly identify the resident jeopardized the safety of the resident.

A review of an email generated by the facility Administrator dated at 04:02 PM stated the staff are expected to respond to the door alarm immediately to ensure no residents leave the Memory Care Unit.

On at 10:00 AM, an interview was conducted with the Administrator. She stated the Memory Care unit I has capacity of about 20 residents. She stated the Licensed Practical Nurse (LPN), realized the alarm was going off and performed a head search which was conducted at about 5:15 AM. She called the Director of Nursing (DON) and made her come into the facility, The Resident's photo was on file. They called the police, made notification to the Physician and to the Son of the resident. She stated the facility was at fault because the staff member (hired from the agency) was in a resident's did not respond to the alarm on the door. She says she explained all of this to the Son and he agreed to take her back to her home where she had lived for 60 years and get her in-home services, He advised the Administrator that she has eloped from her home as well. She stated the resident is no longer in the facility.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on interview and record review, the facility failed to provide documentation indicating staff have a negative ( )statement. The facility failed to provide evidence that staff do not have a communicable for 1 of 3 sampled Staff. (Specifically, Staff B and Staff C).

The findings included:

On a review of the employee personnel record was conducted. The review revealed that Staff B, is a Certified Nursing Assistants(CNA). She was hired on . Her and communicable statement expired on .

A review of the employee personnel file for Staff C was conducted. The review revealed Staff C is also a CNA, who was hired on . The and communicable statement expired on

On at 03:00 PM, the Administrator acknowledged the findings. She stated she would ensure that this matter would be handled.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation, interviews and record review, the facility failed to provide adequate staffing to provide adequate supervision for the residents and provide or arrange for resident services needs for 3 of 4 sampled residents. (Specifically, Resident #4, # 6 snd # 7).
The findings included:

On at 12:30 PM, an observation was made in the Memory Care I unit. There were 24 residents on the unit with one (1)
staff member. There were 10 residents in the Activity area. There was one resident who was observed continuously pacing. She was wandering into the other resident's . The staff member was

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constantly redirecting her. The remaining residents were surrounding the 2 female visitors present. The visitor requested to the staff member that she should change the clothes of Resident # 6. The staff member took the resident to her , while leaving the other residents unattended. The residents in this unit require supervision as they are

On at 12:40 PM, an interview was conducted with Staff C, she indicated she was trying to care for the residents. She stated she needed help. She stated the other staff member had gone to lunch. She also stated that they should have 2 staff working on the unit, but the Manager did not send a staff member to assist her.

On at 10:10 AM, an interview with a confidential staff revealed she had worked in the facility for years. She says they are severely understaffed. She stated on the lunch meals did not reach the residents in their 2:15 PM for lunch,when lunch is to be served at 12:00 PM. She says the same residents did not get their dinner until 6:00 PM when dinner is to be served at 5:00 PM. She says they tell the Administration that they need more staff, but they tell them they can't hire anyone, She says the Administration retaliates if they complain by cutting their hours or taking them off the schedule. She says the Director of Nursing (DON) yells at them.

During a confidential resident interview conducted on at 10:15 AM, the following was revealed. The facility is very short staffed; especially bad on the weekends, The facility has one Certified Nursing Assistant (CNA) on the floor for the weekends. The staff shortage is a tremendous problem.

On at 10:20 AM, a confidential source, stated they only have one CNA per floor on the weekend as well. She says if someone calls off; they do not replace them. She says she has worked on Sundays and they didn't call for a replacement for a CNA that did not come to work.

During a confidential resident interview conducted on , the following was revealed. The facility is very short staffed. The residents have to wait as long as one hour to get an Aide. The facility recently hired a bunch of young girls from an agency. She says when you need them; they are not there, She says they take a long time to deliver food to resident's who are sick and prefer to eat in their . Instead of feeding them first, they feed them last. She says the staff are very respectful. They are just slow, She says they have had 3 or 4 Administrator's recently.

On at 01:00 PM, an interview was conducted with the Administrator, she acknowledge the findings. She further stated they currently have open positions for Direct Care Staff.

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Class III

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

Based on interview and record review, the facility failed to ensure that each of their staff members receive the required training for the resident's Activities of Daily Living (ADL's) for 2 of 3 Staff member records reviewed. (Specifically Staff A and Staff C). The facility failed to ensure that staff who provided direct care obtain a certificate in Reporting , Neglect and , training for 1 of 3 sampled staff. (Specifically, Staff A). The facility also failed to ensure that Staff receive elopement training for 2 of 3 sampled staff. (Specifically Staff A and Staff B).

The findings included:

Review of personnel files revealed the following training concerns.

1) On a review was conducted of the employee records. It was determined that Staff A, a Certified Nursing Assistant, (CNA), who provide direct resident care, did not received the required three (3) hours of ADL training. Her certificate shows she received only one (1) hour.

2) Also, the employee personnel file review revealed Staff A did not have the required 1 hour of in-service training for Reporting , Neglect and , . The review revealed Staff A, only received .75 hours.

3) A review of the employee personnel file was conducted for Staff A. The review revealed that Staff A only received .50 hours of elopement training, as the requirement indicates 1 hour of in-service training is needed.

4) A review of the employee personnel file was reviewed for Staff A. It revealed that Staff A did not evidence of a certificate for one (1) hour of Resident Rights training. Staff A had a certificate indicating only .50 hours had been completed.

5) On a review was conducted of the employee personnel records. It was determined that Staff C, who is a Certified Nursing Assistant (CNA) providing direct care did not have the required three

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(3) hours of ADL training. Staff C only received 1 hour. The records revealed that Staff C was hired on

6) A review of the employee personnel file for Staff B revealed the elopement training certificate was missing from the file.

7) Further review of the employee personnel files for Staff B and Staff C reveal their certificates for Incident reporting was missing from the files. The requirement is met when staff complete one (1) hour of in-service training.

On an interview was conducted with the Administrator. She acknowledged the findings. She stated she would have the staff complete the correct training requirement.

Class III