STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942718	**08/23/2018**
NAME OF PROVIDER OR SUPPLIER **WESTCHESTER OF SUNRISE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **9701 WEST OAKLAND PARK BLVD SUNRISE, FL 33351**	

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

0000 - Initial Comments

An unannounced Complaint Survey, CCR #2017015711, was conducted on through at Westchester of Sunrise, an Assisted Living Facility, License #7440. The facility had deficiencies at the time of the visit.

The Complaint Survey was conducted in conjunction with a Limited Nursing Service (LNS) monitoring visit. Please refer to separate report for findings.

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

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to assess the staffing ratios resulting in the potential for insufficient staffing to meet the needs of the residents residing at the facility

The findings included:

Review of the Standard Survey conducted on revealed a citation was issued related to 8 AM medications being administered after 10 AM, greater than the one hour per the standard rule of administration one hour before or one hour after the due time.

Review of a Level of Care form, an assessment conducted by a licensed nurse, revealed a Level 4 status requires with activities of daily living (ADL); a Level 3 status requires with ADLs; a Level 2 status requires some assistance with ADLs and Level 1 status requires minimal assistance with ADLs.

Review of the ALF staffing schedules revealed 2 staff members are scheduled for the night shift. The ALF census on was 124. Of the 124 residents, 16 residents were classified as requiring Level 4 assistance; 11 residents were classified as requiring Level 3 assistance; and 18 residents were classified as requiring Level 2 assistance for a total of 45 residents requiring assistance with ADLs.

On at 3:00 PM, an interview was conducted with the ALF Manager inquiring about the facility call bell system. The ALF Manager stated when the resident activates the call system from their , it lights up at the nursing station on the first floor. The ALF Manager stated a staff member is posted at the nursing station at all times to be available to answer the call bells. The ALF Manager stated the night shift aides would do rounds for the Level 3's and 4's and would go into the , 2 to 3 hours. With a census of 124 residents, and 2 staff members working the night shift, if one staff member is posted at

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the nursing station, then that would be one staff member responsible for 124 residents, 16 of which are classified as Level 4 and 11 classified at Level 3.

On at 3:26 PM, an interview was conducted with the Wellness Coordinator who stated on the morning shift 2 come in at 6:00 AM and one at 6:30 AM; she is considered the nurse on the day shift and on the evening shift there is a Licensed Practical Nurse; and there are 2 medication technicians (med tech) on the night shift. The Wellness Coordinator stated on the night shift, the med techs focus on the Level 3 and Level 4 residents.

On at 1:05 PM, an interview was conducted with a family member and private duty aide for Resident #4 in the resident's . The family member expressed she frequently finds her mother in bed with a wet adult brief and she is not sure how long she has been sitting in wet. The family member stated she is not sure what state her mother would be in if she did not have a private duty aide. On at 1:10 PM, the resident's sacral was observed. If the resident was , the location of the would be susceptible to being in contact with the . The family member stated Resident #4 is supposed to be a Level 4 but she was not sure what that meant. She stated not long ago she activated the call light and it took 2 hours for someone to respond and when the aide finally came she said she could not change the resident by herself, left the never came back. The family member stated she had to help the resident herself. The family member expressed that she does not think the resident is checked on very frequently at night time and maybe that is why the is not getting much better.

On at 1:45 PM, an interview was conducted with Resident #5 and his private duty aide in the resident's . The private duty aide stated he is with the resident for 8 hours a day to assist with ADLs and does a last check and change before he leaves at 6 PM. The private duty aide stated frequently when he arrives in the morning the resident has been and possibly sitting in the wet for hours. The private duty aide stated he does not think the resident is checked very often throughout the night. Review of the resident's record revealed he is classified as requiring Level 4 care.

On at 2:20 PM, an interview was conducted with Resident #6 in her . The resident was observed to be quite independent, able to care for herself and administer her own medications. An inquiry was made if she did require assistance what would she do, to which she stated she would call downstairs as opposed to using the call bell cord as she has her phone with her at all times. An inquiry was made if she required assistance at 2 AM what would she do, to which she stated she hopes someone would be downstairs at that time to answer the phone, but she has never had to call at that time, but you never know, things could change, I could and break a bone.

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On at 12:20 PM, an interview was conducted with a med tech on the first floor. The med tech stated she starts her shift at 6 AM and assists those residents that require and , bathing changing, dressing and getting them ready for breakfast. She stated there are 2 aides per floor, each has a hallway. The aide confirmed 2 aides were responsible for approximately 62 residents which is a heavy workload, so she stated, they try to work together but it is not easy. Additionally she stated even with the residents who are independent you still have to check on them and make their beds. She further stated once the morning ADLs are done, she then has to be on the medication cart to pass out the morning medications, stating frequently the 8 AM medications are not able to be given until 10 AM. She stated she has talked to them (Administration) about this, and told them maybe on the night shift they could get a few more of the heavy workload residents cleaned up so it would give the day shift a lighter load, but nothing changes.

On at 1:45 PM, an interview was conducted with a Certified Nursing Assistant (CNA) on the second floor who stated she has a 6 AM start. She stated there are 2 of them for the second floor, confirming it is about 30 residents each to look after. She stated the night shift tries to get 2 residents cleaned up, however they are still in bed so they have to get them up and in their wheelchairs for breakfast plus they still have to get the additional residents ready for the day. She stated even with the independent residents, they still have to check on them and make their beds. Further, she stated once they get the morning care done, they have to pass out medications. She stated they (Administration) know about this but nothing ever seems to be done and nothing changes.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on interview and record review the Assisted Living Facility (ALF) failed to appropriately document the status of 3 of 3 residents reviewed for admission and transfer, Resident #1, Resident #2 and Resident #3 as evidenced by failing to assess the status of a for Resident #1; failure to assess skin condition for Resident #2; and failure to assess the status of Resident #3 upon return to the facility post hospitalization; and failed to have complete and accurate clinical records, for 2 of 3 residents reviewed, Resident #1 and Resident #3.

The findings included:

1) Resident #1 was admitted to the ALF on with diagnoses to include muscle and pylonidal to the sacral area. Review of the Discharge Instructions dated from the rehabilitation center the resident was residing at, documented care instructions to cleanse the

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pylonidal , with normal , pack with packing strip daily with home health nurse arranged to perform the daily dressing changes.

Review of the initial admission Progress Note dated documents the resident's skin is clear and intact, no cuts, scrapes or noted. There is no documentation of the status of the dressing to the sacral area. Progress Note documentation on and have no mention of any issues identified with the dressing to the sacral area or any assessment or description of the sacral being addressed by the home health agency. The next entry in the Progress Notes is dated documenting 'Resident noted with open area to area, was sent to hospital for evaluation.' There is no evidence of documentation in the clinical record about the status of the sacral from admission on .

On at 12:00 PM, a request was made to the ALF Manager to provide the physician orders, laboratory results, medication and treatment records and physician progress notes as they are not included in the clinical record that was provided yesterday.

On at 12:05 PM, the Wellness Coordinator stated what they provided yesterday was all they have or could find. She stated they do not have a medical records person but went through all the boxes yesterday and what they gave is what they found. The Wellness Coordinator could not speak to the status of the resident's stating she was not at the facility at that time. The ALF Manager could not speak to the status of the resident's .

2) Resident #2 was admitted to the ALF on with diagnoses to include , , and .

Review of Progress Notes dated documents the resident is noted with 'multiple to upper body and open area to left area. The physician was notified and cream was applied to body'.

Review of a Treatment Record dated documents 'Dressing change to left 3 times weekly' with a hand written notation next to the entry is written HH (Home Health). Review of the Progress Notes reveals no documentation of the status of the left area requiring home health intervention 3 times a week.

Review of a physician order dated documents 'Send patient to ER (emergency) in AM, diagnosis multiple open wounds over body. Sent to (name of hospital family request). Review of the Progress Notes reveals no evidence of documentation of the status of Resident #2's skin status from when a was observed to upper body and open area to left area. Further review of

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the Progress Notes reveals no documentation the resident was transported to the hospital per physician orders on .

Review of a Progress Note dated documents the resident slid out of her wheelchair; home health was called in to redo her bandages which slid off. There is no evidence of documentation of where the bandages were located that off and no documentation of what was the status under those bandages.

Review of a Progress Note dated documents the resident's bandages keep slipping off; home health nurse visited patient today. There is no evidence of documentation of where the bandages were located that keep slipping off and no documentation of what was the status under those bandages.

Review of a Physician Order dated documents 'Send patient to (name of hospital #1) for worsening (skin condition); increase risk for , patient on high dose of needs close monitoring of glucose.' Resident #2 was not sent to the hospital as ordered.

The next and last entry in the Progress Notes dated document the resident was seen by the physician and skin condition getting worse. Resident to be brought to (name of hospital #1 physician ordered the resident to be transferred to on) to rule out .

Review of a Physician Order dated documents 'Send patient to (name of hospital #2) for worsening (skin condition) risk for , patient on high dose of needs close monitoring.'

Review of the Progress Notes revealed no documentation what date or what time Resident #1 was transferred to the hospital and no documentation if Resident #1 was transferred to Hospital #1 or Hospital #2. As of , Resident #1 was not a resident of the facility.

On at 3:15 PM an interview was conducted with the Wellness Coordinator. She was unable to speak to the status of Resident #1's skin condition.

3) Resident #3 was admitted to the ALF on with diagnoses to include , and slight .

Review of Progress Notes dated document the resident has no complaints, appetite good. Review of a Progress Notes dated documents the resident's condition is stable, alert and oriented and able to make needs known. The next entry is dated documenting the resident was

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seen by the physician and an order received to send the resident to the hospital for a diagnosis of anorexia. There is no evidence of documentation for the 7 day period leading up to the physician ordering the resident to be transferred to the hospital. The next entry is dated documenting the resident is being transported back to the hospital for evaluation of behaviors. There is no evidence of documentation when the resident returned to the facility from the transfer to the hospital and no evidence of documentation of her status on return.

On at 2:00 PM an interview was conducted with the ALF Manager and Wellness Coordinator requesting to be provided with the physician order for discharge of the resident on and evidence of documentation of the date of the resident's return to the facility and status on readmission from the hospital visit. The ALF Manager and Wellness Coordinator stated they are unable to find a physician order for transfer on and could not speak to the date the resident was readmitted to the facility or status on readmission from the hospital stay.

Class III