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	AL11911449	09/21/2018
NAME OF PROVIDER OR SUPPLIER **PLAZA OF HALLANDALE BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **3535 SW 52ND AVENUE** **PEMBROKE PARK, FL 33023**	

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0000 - Initial Comments

An unannounced licensure complaint survey, CCR #2018007665, commenced on and concluded on at Plaza of Hallandale Beach, License #5120. The facility had deficiencies identified at the time of the survey.

A Generator Monitoring survey was included in the above licensure complaint survey.

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

Based on observation, interview and record review, the facility failed to ensure a resident was reassessed for continued residency upon significant health changes (including diagnosis and dietary changes) to ensure that the resident's needs could be met in the facility. It was also determined that the facility failed to maintain an accurate, updated and complete Resident Health Assessment (AHCA form 1823) to ensure appropriate care and services were provided, for 1 out of 3 sampled resident reviewed (Resident #1).

The findings include:

Review of the file for Resident #1 revealed three (3) Health Assessments (AHCA 1823 form) completed for Resident #1. Health Assessment #1 dated documents diagnosis as ( ), (Chronic Kidney); ; . The form also documents the resident requires supervision in eating. Health Assessment #2 dated documents diagnosis ( ), (Chronic Kidney), , , . Special diet instructions documented as mechanical soft with thin liquids in sippy cup including staff assistance and special precautions noted as difficulty swallowing. Health Assessment #3 dated documents diagnosis ( ), (Chronic Kidney), ; . Special diet instructions documented as mechanical soft with thin liquids in sippy cup including staff assistance. All (3) 1823 Health Assessments (, , and) are inaccurate, missing diagnosis and information regarding instructions for high risk of choking precautions and the type of care required for eating/feeding for Resident #1. Further record review of physician orders revealed additional diagnosis of , , and choking. However, these additional diagnosis were not included in the most recent AHCA form 1823 dated .

Further record review revealed written Physician's Orders for Resident #1's therapeutic diet (including

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preparation instructions, cueing for the resident and staff assistance) dated from through .

Review of progress notes dated on (10am)- "CNA reported resident dining area. Cleaned up and bought to activities. Resident found with eyes closed, clear mucus coming from noise, pulse weak. Skin warm to touch. Unable to get her to speak. Sternal rub done to resident, no response of opening eyes. While wiping resident's nose noticed she was not breathing. Rescue called. As started rescue was in building. Resident taken to {name of hospital}. "

A review of the hospital report for Resident #1 indicated that police and Emergency Medical Services ( ) personnel arrived at the facility and transferred Resident #1 to the nearest hospital for treatment on at 10:30AM. The report further indicated that Resident #1 was unresponsive, in , and was intubated on at 10:45 AM and at 11:43AM. A review of the hospital records dated indicated Resident #1 arrived in the Emergency (ER) by 911 transport at 10:30 AM with the diagnosis of and unresponsive. The ER physician assessment notes documented "There was large amount of food particles in , , (throat)" during the removal of a king tube prior to intubating Resident#1 and remained in . A review of the Medical Examiner External Examination report dated , reveal the Circumstances, Cause of and Final Diagnosis as "Choking on Food". In addition, The Certificate of issued on documented the cause of as an "Accident and "Choking on Food".

During interviews with Staff A and B on and , both stated that they have performed care for Resident #1 over the last five years. However, both were unaware of any special eating/feeding instructions or dietary needs.

During a phone interview with the Director of Nursing (DON, who is no longer employed) on at 7:50PM, it was revealed that Resident #1 received a therapeutic diet that changed from puree to mechanical soft. The former DON acknowledged Resident #1 had a few swallowing tests and recalls the Doctor's diagnosis of , , , coughing and choking but failed to update the AHCA form 1823 for current and accurate information . She continued to state that Resident#1 was independent in eating, however, would keep food in her mouth for a while without swallowing.

During an interview with the Administrator on at 11:00AM, she stated she was not aware of these orders. She also confirmed the facility had not reassessed the resident for continued residency with respect to the resident's physician orders, dietary needs and care needs due to a decline in health status. All findings were acknowledged and confirmed by the Administrator; no additional documentation presented at this time.

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See A 028 for additional findings
Class II

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

Based on observation, interview and record review, the facility failed to provide the necessary care and services to meet the needs of 1 of 3 sampled residents assessed to require a therapeutic diet (Resident #1). As evidenced of the facility's failure to communicate with the facility's staff regarding Resident #1's therapeutic diet order by healthcare provider. Specifically, the facility failed to ensure staff followed dietary restrictions ordered by a healthcare provider due to swallowing difficulty, identified by swallowing test with a diagnosis of , , which resulted in Resident #1's by choking on food.

The findings include:

Review of Resident #1's Resident/Patient Concern Report dated revealed the following. "Family stated she has communication issues with the DON. Stated resident does not look well today. She would like better communications- such as when resident is not doing good like today. A report every 2 to 3 weeks would be good. "

Review of Resident #1's progress notes revealed the following. On (4:40pm) - "Dr. {name} visited resident today. Resident presents this afternoon. Family concerned something is wrong. B/P monitoring twice day X7days. Family informed by doctor of present orders. " On (10am)- "CNA reported resident dining area. Cleaned up and bought to activities. Resident found with eyes closed, clear mucus coming from noise, pulse weak. Skin warm to touch. Unable to get her to speak. Sternal rub done to resident, no response of opening eyes. While wiping resident's nose noticed she was not breathing. Rescue called. As started rescue was in building. Resident taken to {name of hospital}. "

A review of the hospital report for Resident #1 indicated that police and Emergency Medical Services ( ) personnel arrived at the facility and transferred Resident #1 to the nearest hospital for treatment on at 10:30AM. The report further indicated that Resident #1 was unresponsive, in , and was intubated on at 10:45 AM and at 11:43AM. A review of the hospital records dated indicated Resident #1 arrived in the Emergency (ER) by 911 transport at 10:30 AM with the diagnosis of and unresponsive. The ER physician assessment notes

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documented "There was large amount of food particles in , , (throat)" during the removal of a king tube prior to intubating Resident#1 and remained in . A review of the Medical Examiner External Examination report dated , reveal the Circumstances, Cause of and Final Diagnosis as "Choking on Food". In addition, The Certificate of issued on documented the cause of as an "Accident and "Choking on Food".

During a record review of facility records and an interview with the Administrator on (10 A) and at 1 PM, revealed the facility didn't have any documentation indicating the facility had investigated the incident that occurred on for Resident #1. She further stated no adverse incident report had been completed and filed with the Agency. The Administrator stated that she escorted Resident #1 from the dining breakfast to the TV activity at 10:00AM, the resident was alert and talking, and did not demonstrate any signs of distress.

A record review of Physician's Orders for a swallowing test revealed: an undated Physician's Order from speech , , for a swallowing test; and, a Physician's Order dated for another swallowing test, with diagnoses of " , , , choking, and coughing" listed. Further review of a Physician's Order dated states, "effective, begin soft solids such as tuna/chicken salad, including soft sandwich bread. Continue puree for all other foods; thin liquids continue to be permissible as long as presented in , , cup *IMPORTANT - patient requires minimum ½ cup full for all thin liquids". A Physician's Order dated states (emphasized) a mechanical soft diet and provides direction, "After every two mouth full of food, ensure resident swallows by giving water " and specifically indicates, "If resident pockets food in mouth or , , , feeding may return to puree. Remind to drink after EVERY two solid food swallowed; she has the potential to feel full in throat. Effective discontinue previous order of . Begin chopped diet, NO sandwiches, all soft consistencies allowed: mashed potatoes, pudding". A Physician's Order dated states "Begin presentation of white, whole wheat and rye bread to patient at meals. Cut slices into 4 parts with butter. NO bagels or any other dense breads until further order. Patient must have water presented to her every two mouth full of ALL solid foods including bread". Additional record review revealed a Physician's Order for another swallowing test performed on , and states "Hand on assistance with eating/feeding for ALL meals". On , the Doctor Ordered the facility staff to "assist in feeding/eating and give water after every two spoonful of food again".

During an interview with Staff B on at 11 AM and at 9:45AM, she stated that Resident #1 was escorted by wheelchair from her the dining breakfast on approximately at 9:00AM and she set her up at the table; then went on to other assignments. Staff B stated that Resident#1 was independent in eating and she just supervised by going around to the tables. Staff B stated during her five years of employment at the facility she provided care to Resident #1. However,

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she was not aware of any dietary needs, swallowing difficulty, assistance with meal requirements and/or pocketing of food for Resident #1

During an interview with Staff A on at 11:30 AM and at 10:00AM, she stated that she observed Resident #1 slumped over her wheelchair around 10:00AM on in the TV/Activities . Staff A stated she went to assist Resident #1; cleaned her mouth, which had some food residue and mucus. However, Resident #1 was unresponsive. She then alerted Staff B to get help and the former DON (Director of Nursing) activated 911, took the resident's vital signs and administered ( ) until arrived. Staff A stated she has been employed at the facility over 5 years and that she provided care to Resident #1. However, she was not aware of any dietary needs, swallowing difficulty, assistance with meal requirements and/or pocketing of food for Resident #1

The Chef stated during interviews conducted on at 10:15AM and at 10:30AM that Resident #1 received a therapeutic mechanical soft diet. He further reported that Resident #1 did not choke or throw up in the dining breakfast on between 9:00AM-10:00AM and was unaware of any swallowing difficulty. During review of the 4-week menu cycle, the Chef identified the breakfast meal served on , which contained a choice of eggs (2oz); French toast (1pc); half banana; hot/ cereal (1cup); juice & milk (6oz). A request was made for the facility's therapeutic menu, which requires a licensed or registered nutritionist/dietician signature annually for review. The facility did not have the approved therapeutic menu it and the Chef explained how he prepares the special therapeutic diet meals by using what is on the menu and either puree or chop to mechanical soft.

Review of the file for Resident #1 revealed multiple Health Assessments completed for Resident #1. Health Assessment #1 dated documents diagnosis as ( ), (Chronic Kidney); ; ; , . The form also documents the resident requires supervision in eating. Health Assessment #2 dated documents diagnosis ( ), (Chronic Kidney), , , , , . Special diet instructions documented as mechanical soft with thin liquids in sippy cup including staff assistance and special precautions noted as difficulty swallowing. Health Assessment #3 dated documents diagnosis ( ), (Chronic Kidney), ; , , , , . Special diet instructions documented as mechanical soft with thin liquids in sippy cup including staff assistance. All (3) 1823 Health Assessments (, , and) are inaccurate, missing diagnosis and information regarding instructions for high risk of choking precautions and the type of care required for eating/feeding for Resident #1. Further record review of physician orders revealed additional diagnosis of , , and chocking. However, these additional diagnosis were not included in the most recent AHCA form 1823.

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During an interview with the former Director of Nursing (DON, who is no longer employed at the facility) on at 7:50 PM, she stated the morning of around 9:00AM she was performing morning medication. A CNA (Certified Nurse Assistant) brought Resident #1 to the nurses' station and was unresponsive and not breathing. The DON proceeded to activate 911 and performed until arrived. The paramedics inserted a tube down Resident #1's throat to assess any obstruction and transferred the resident to the local ER. The DON stated she called and left voice message with Resident#1's son who is the POA (Power of Attorney). It was inquired if the resident received a therapeutic diet, the DON responded yes. The DON explained that the order would change from puree to mechanical soft and that Resident #1 had a few swallowing tests. The DON stated she recalls the Physician's diagnosis of , , , coughing and choking but did not update the AHCA 1823 form for current and accurate information. She continued to state that Resident#1 was independent in eating, however, would keep food in her mouth for a while without swallowing.

The Administrator confirmed, the deficient practice of the facility's personnel not following the Physician orders dated ; ; ; ; and for a therapeutic diet; hands on assistance while eating/feeding with a pause after two mouthfuls of food; and offer a drink from a sippy cup. She further acknowledged that the facility staff was unaware of the resident's history of pocketing food in her mouth, which could cause choking. The event of Resident #1's condition and lack of appropriate supervision and assistance led to the incident on resulting in the of Resident #1.

See A 010 for additional findings
Class II

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, record review and interview, the facility failed to ensure a health care provider's order for , testing two times a day was followed; in addition to breathing treatments, for 1 out of 3 sampled residents (Resident #1).

The findings included:

A record review of Resident #1's Physician's Orders; the DON (Director of Nursing) progress notes; and the MOR (Medication Observation Record) from 2017- , 2018, revealed discrepancies. Review of the MORs from , 2017 - , 2018, revealed the following orders:
Liquid-take 10cc by mouth every 6 hours as needed for , (as needed /PRN), 2.5-0.5

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mg/3ml -use 1 vial via jet every 6 hours as needed for . The progress notes written by the DON state Resident #1 had a persistent and breathing treatment and medicine given.

Review of Physician's Orders and chest x-rays (; ; ; and) revealed a diagnosis of , Lung and Productive . Further review of Resident #1's 1823's and physician notes document diagnosis of ( ), Chest and , Hypertensive and Chronic Kidney with Failure.

However, review of Resident #1's MORs from , 2017 - , 2018, revealed no documentation indicating (no signatures/no initials) the medication or breathing treatment given during (3) dates written in the progress notes.

a) 6pm notes state breathing treatment given - treatment not documented on the MOR
b) 10PM notes state breathing treatment given - treatment not documented on the MOR
c) 6:30PM notes state breathing treatment given - treatment not documented on the MOR

Further record review revealed Physician's Order dated for (B/P), take 2x daily for 7 days. A record review of the facility's monitoring sheet for Resident #1 notes: B/P twice a day 9AM and 5 PM x1 week. Further review of the monitor sheet revealed the resident's , was only taken once as documented (without initials) by the following entry: (9AM) - , .

The Administrator confirmed the findings on at 11:30AM and no further documentation provided.

Class III

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

Based on observations, record review and interviews, it was determined that the facility failed to maintain an approved therapeutic menu by a licensed or registered dietitian with documentation of a signature, registration or license number, and date of annual review. In addition, the facility failed to ensure a therapeutic diet was prepared and served as ordered, for 1 out of 3 sampled residents (Resident #1).

The findings included:

A request made on and at 9:45AM to the Chef to review the therapeutic menu, which

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requires a licensed or registered nutritionist/dietician signature annually for review was not located. The Chef stated that the facility does not have one and explained how he prepare the special therapeutic diet meals by using what is on the menu and either puree or chop to mechanical soft.

A record review of the 4 week menu approved, signed, and dated by the Registered Dietician was conducted. The facility failed to provide a therapeutic recipe/menu by licensed or registered dietitian with documentation of a signature, registration or license number, and date of annual review.

During an interview, with the Chef on at 9:30AM, he stated the process of obtaining a special therapeutic diet order, which starts with a doctor order. The nurse receives the order from the doctor and completes the "Diet Order Notification Form". The Nurse submits the form to the Chef and it is stored in a binder with a picture of the resident receiving a special therapeutic diet and the form. "Diet Order Notification Form" only indicates: regular; puree; mechanical soft; and liquid thicken. It does not state any directions of how to prepare; consistency; and portion size. In addition no staff instructions for how to assist / supervise the resident. The Chef stated he was unaware of Resident #1's swallowing difficulty and detail dietary instructions and that the facility's Registered Dietician does not review the orders/menus.

A record review of Physician's Orders for a swallowing test revealed: an undated Physician's Order from speech for a swallowing test; and, a Physician's Order dated for another swallowing test, with diagnoses of " , , , choking, and coughing" listed. Further review of a Physician's Order dated states, "effective, begin soft solids such as tuna/chicken salad, including soft sandwich bread. Continue puree for all other foods; thin liquids continue to be permissible as long as presented in , , cup *IMPORTANT - patient requires minimum ½ cup full for all thin liquids". A Physician's Order dated states (emphasized) a mechanical soft diet and provides direction, "After every two mouth full of food, ensure resident swallows by giving water " and specifically indicates, "If resident pockets food in mouth or , , feeding may return to puree. Remind to drink after EVERY two solid food swallowed; she has the potential to feel full in throat. Effective discontinue previous order of . Begin chopped diet, NO sandwiches, all soft consistencies allowed: mashed potatoes, pudding". A Physician's Order dated states "Begin presentation of white, whole wheat and rye bread to patient at meals. Cut slices into 4 parts with butter. NO bagels or any other dense breads until further order. Patient must have water presented to her every two mouth full of ALL solid foods including bread". Additional record review revealed a Physician's Order for another swallowing test performed on , and states "Hand on assistance with eating/feeding for ALL meals". On , the Doctor Ordered the facility staff to "assist in feeding/eating and give water after every two spoonful of food again".

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Review of the file for Resident #1 revealed multiple Health Assessments completed for Resident #1. Health Assessment #1 dated . . . . . documents diagnosis as . . (. . . . .), . . (Chronic Kidney); , ; , , , . The form also documents the resident requires supervision in eating. Health Assessment #2 dated . . . . . documents diagnosis (, ,), (Chronic Kidney), , , , , ... Special diet instructions documented as mechanical soft with thin liquids in sippy cup including staff assistance and special precautions noted as difficulty swallowing. Health Assessment #3 dated . . . . . documents diagnosis . . (. . . . .), . . (Chronic Kidney . . . . .), , ; , , , , , . Special diet instructions documented as mechanical soft with thin liquids in sippy cup including staff assistance. All (3) 1823 Health Assessments (, , and) are inaccurate, missing diagnosis and information regarding instructions for high risk of choking precautions and the type of care required for eating/feeding for Resident #1. Further record review of physician orders revealed additional diagnosis of , , and chocking. However, these additional diagnosis were not included in the most recent AHCA form 1823.

During interviews with Staff A and B on . . . . . and . . . . . at 9:45AM, both stated that they have performed care for Resident #1. However, both were unaware of any special eating/feeding instructions or dietary issues.

During an interview with the Administrator, on . . . . . at 11:00AM, stated she was not aware of the written Physician's Orders for Resident #1's therapeutic diet and staff assistance dated ; ; and . . . . . The resident's therapeutic diet was not prepared and served as written Physician's Orders with detail instructions. All findings acknowledged and confirmed by the Administrator and no additional documentation presented at this time.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on observation, interview and record review, the facility failed to complete and submit an adverse incident report to the Agency for Health Care Administration regarding an event that resulted in . . . . of a resident by choking on food for 1 out of 3 sampled resident records (Resident #1).

The findings include:

A record review of the facility's adverse incident reports revealed the facility failed to complete and submit an adverse incident report regarding the incident that occurred on . . . . . for Resident #1, which

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resulted in by choking on food.

During an interview with Administrator on at 7:00PM, revealed that an incident occurred on with Resident #1, which involved a medical emergency of unresponsiveness and resulted in transferred to local hospital. She stated that the hospital called the facility on approximately 11:50AM, to inform of the passing of the resident. The Administrator stated that the hospital did not state cause of .

Further interview with the Administrator, on at 11:00AM, revealed the facility had no documentation indicating an investigation of the incident occurred on for Resident #1 and further stated no adverse incident report had been completed and filed with the Agency for HealthCare Administration.

The Administrator confirmed that the event of Resident #1's condition resulted in , which the facility personnel could have exercise control over by following the written Physicians Orders dated ; ; and . The facility failed to follow the orders for a therapeutic diet and hands on assistance while eating/feeding; with a pause after two mouthful of food and offer a drink from a sippy cup. In addition, facility staff was unaware of the resident pocketing food in her mouth in which could cause choking.

Class III