STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969271	12/20/2018
NAME OF PROVIDER OR SUPPLIER **RENAISSANCE SENIOR LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **2100 10TH AVE** **VERO BEACH, FL 32960**	

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR #2018014842, was conducted on , and at Renaissance Senior Living, License #13068. The facility had deficiencies identified at the time of the survey.

0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on record review and an interview, the facility failed to ensure the health assessments (AHCA Form 1823) were completed and accurate for 2 out of 4 sampled residents (Residents #2 and #3).

The findings included:

a) The health assessment for Resident #2 dated did not indicate whether or not the resident was a "danger to self or others". The "yes" or "no" inquiry box was left blank with a note stating, "he likes to and pace". Additionally, another assessment dated did not have documented whether or not the resident required assistance with medication, or what type of diet the resident was to receive.

b) The health assessment dated for Resident #2 documented that the resident was not at risk for elopement by a marked "no" for "elopement risk" on page 1. During review of the resident's incident reports, it was revealed that the resident attempted to elope from the facility's secured unit on . During interview with the Licensed Practical Nurse (LPN) on at 11:00 AM, she stated that Resident #2 is at risk for eloping. The assessment did not accurately reflect the resident's current status as an elopement risk.

c) The health assessment dated for Resident #3 noted that the resident required "total care" with ambulation, bathing and transferring. However, the resident's admission progress note dated documents that the resident "ambulates with a walker" and is a "one person assist with all ADLs (activities of daily living)". There was no documentation to show that the level of assistance required with the resident's ADLs on the health assessment was corrected.

AHCA Form 1823 information was not complete and accurate on the assessments for these residents. The omitted information may be obtained orally from the health care provider and documented on the assessment by facility staff, with the name of the provider, name of facility staff recording the information, and the date the information was provided. The assessments did not have the omitted or erroneous information corrected and documented. The findings were acknowledged by the Resident

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Care Director during interview on at 1:00 PM. The facility provided no additional information for review at this time.

Class III

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

Based on record review and interview, it was determined the facility failed to have a -to- medical examination and completion of a new health assessment (AHCA Form 1823) by a health care provider after a significant change for 1 out of 4 sampled residents (Resident #1).

The findings included:

On , during record review for Resident #1, a completed Health Assessment (AHCA Form 1823) dated was reviewed. The health assessment indicated that the resident required "supervision" with bathing and grooming, and was "independent" with eating and transferring.

During interview with the Licensed Practical Nurse (LPN) on at 11:00 AM, she stated that the resident was admitted to the facility walking and was assisted with activities of daily living (ADLs), but the resident had a decline and was a "two person assist" with transfers and bathing, could not walk anymore and was fed by staff. The resident was assessed for hospice services as noted in the resident's recorded Progress Notes on . Review of the resident's Progress Notes showed the following significant change in the resident's condition:

a. : Resident continues to require more assist for all ADLs, transfers and toileting needs. 2+ aides are required. Resident is unable to follow simple commands to help with ADLs. Family and primary care physician are aware of resident's decline.
b. : Resident requires "2+ people" for all transfers and toileting needs.
c. : She is "total care resident". "3 person assist" to prepare for bed and transfer.
d. : Resident unable to feed self "for months now". Resident is on "every 2 hour toileting program and is person assist".

The deterioration in the resident's health status was not a gradual change in the abilities to carry out the ADLs that accompany the aging process. The change in condition was not assessed using the health assessment, AHCA Form 1823. This form is used to monitor residents for continued residency and appropriateness for the Assisted Living Facility (ALF). The resident record did not contain a new assessment completed after the resident's significant change in her health status.

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Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(I)

Based on record review and interviews, the facility failed to identify 1 out of 3 sampled residents (Resident #2) at risk for elopement by maintaining a photo ID in the resident's record, and by making a daily effort to ensure the resident has identification on them.

The findings included:

On at 11:00 AM, the Licensed Practical Nurse (LPN) stated that Resident #2 was at risk for elopement as the resident displays exit seeking behavior. Review of an Incident Report in the resident's record shows the resident attempted to exit the secured unit at the facility on . During review of the record, the only picture of the resident that was found was a driver's license issued in 2014. During interview with the resident's representative on at 1:30 PM, she stated that the resident eloped from the Assisted Living Facility (ALF) where he resided prior to this facility.

On at 12:00 PM, Resident #2 was observed with no apparent identification on his person. The LPN stated during interview at this time that the resident did not have any identification on him, and the facility staff did not check for this. She also stated that the resident's record did not have a current picture of the resident on file.

Residents at risk for elopement or with any history of elopement must be identified. The facility's policies and procedures for elopement must include, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address and telephone number. The facility's file must contain the resident's photo identification within 10 days of admission or within 10 days of being assessed at risk for elopement subsequent to admission.

These findings were acknowledged by the Resident Care Director on at 1:00 PM. The facility provided no additional information for review at this time.

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

0000 - Initial Comments

AMENDED REPORT

An unannounced licensure complaint survey, CCR #2018014842 and CCR #1018014795, was conducted on , and at Renaissance Senior Living, License #13068. The facility had deficiencies identified at the time of the survey.

0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on record review and an interview, the facility failed to ensure the health assessments (AHCA Form 1823) were completed and accurate for 2 out of 4 sampled residents (Residents #2 and #3).

The findings included:

a) The health assessment for Resident #2 dated did not indicate whether or not the resident was a "danger to self or others". The "yes" or "no" inquiry box was left blank with a note stating, "he likes to and pace". Additionally, another assessment dated did not have documented whether or not the resident required assistance with medication, or what type of diet the resident was to receive.

b) The health assessment dated for Resident #2 documented that the resident was not at risk for elopement by a marked "no" for "elopement risk" on page 1. During review of the resident's incident reports, it was revealed that the resident attempted to elope from the facility's secured unit on . During interview with the Licensed Practical Nurse (LPN) on at 11:00 AM, she stated that Resident #2 is at risk for eloping. The assessment did not accurately reflect the resident's current status as an elopement risk.

c) The health assessment dated for Resident #3 noted that the resident required "total care" with ambulation, bathing and transferring. However, the resident's admission progress note dated documents that the resident "ambulates with a walker" and is a "one person assist with all ADLs (activities of daily living)". There was no documentation to show that the level of assistance required with the resident's ADLs on the health assessment was corrected.

AHCA Form 1823 information was not complete and accurate on the assessments for these residents. The omitted information may be obtained orally from the health care provider and documented on the assessment by facility staff, with the name of the provider, name of facility staff recording the

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information, and the date the information was provided. The assessments did not have the omitted or erroneous information corrected and documented. The findings were acknowledged by the Resident Care Director during interview on at 1:00 PM. The facility provided no additional information for review at this time.

Class III

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

Based on record review and interview, it was determined the facility failed to have a -to- medical examination and completion of a new health assessment (AHCA Form 1823) by a health care provider after a significant change for 1 out of 4 sampled residents (Resident #1).

The findings included:

On , during record review for Resident #1, a completed Health Assessment (AHCA Form 1823) dated was reviewed. The health assessment indicated that the resident required "supervision" with bathing and grooming, and was "independent" with eating and transferring.

During interview with the Licensed Practical Nurse (LPN) on at 11:00 AM, she stated that the resident was admitted to the facility walking and was assisted with activities of daily living (ADLs), but the resident had a decline and was a "two person assist" with transfers and bathing, could not walk anymore and was fed by staff. The resident was assessed for hospice services as noted in the resident's recorded Progress Notes on . Review of the resident's Progress Notes showed the following significant change in the resident's condition:

a. : Resident continues to require more assist for all ADLs, transfers and toileting needs. 2+ aides are required. Resident is unable to follow simple commands to help with ADLs. Family and primary care physician are aware of resident's decline.
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c. : She is "total care resident". "3 person assist" to prepare for bed and transfer.
d. : Resident unable to feed self "for months now". Resident is on "every 2 hour toileting program and is person assist".

The deterioration in the resident's health status was not a gradual change in the abilities to carry out the ADLs that accompany the aging process. The change in condition was not assessed using the health assessment, AHCA Form 1823. This form is used to monitor residents for continued residency and

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appropriateness for the Assisted Living Facility (ALF). The resident record did not contain a new assessment completed after the resident's significant change in her health status.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(I)

Based on record review and interviews, the facility failed to identify 1 out of 3 sampled residents (Resident #2) at risk for elopement by maintaining a photo ID in the resident's record, and by making a daily effort to ensure the resident has identification on them.

The findings included:

On at 11:00 AM, the Licensed Practical Nurse (LPN) stated that Resident #2 was at risk for elopement as the resident displays exit seeking behavior. Review of an Incident Report in the resident's record shows the resident attempted to exit the secured unit at the facility on . During review of the record, the only picture of the resident that was found was a driver's license issued in 2014. During interview with the resident's representative on at 1:30 PM, she stated that the resident eloped from the Assisted Living Facility (ALF) where he resided prior to this facility.

On at 12:00 PM, Resident #2 was observed with no apparent identification on his person. The LPN stated during interview at this time that the resident did not have any identification on him, and the facility staff did not check for this. She also stated that the resident's record did not have a current picture of the resident on file.

Residents at risk for elopement or with any history of elopement must be identified. The facility's policies and procedures for elopement must include, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address and telephone number. The facility's file must contain the resident's photo identification within 10 days of admission or within 10 days of being assessed at risk for elopement subsequent to admission.

These findings were acknowledged by the Resident Care Director on at 1:00 PM. The facility provided no additional information for review at this time.

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These findings were acknowledged by the Resident Care Director on at 1:00 PM. The facility provided no additional information for review at this time.

Class III