STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967048	**01/18/2019**
NAME OF PROVIDER OR SUPPLIER **TYVAL ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **3526 GENEVRA AVE** **BOYNTON BEACH, FL 33436**	

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR #2019000479, was conducted on through at Tyval Assisted Living Facility, License #11128. The facility had deficiencies identified at the time of the survey.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on interview and record review, the facility failed to honor resident rights and provide a safe and decent living environment which was free from the use of physical . This was due to staff member A allowing 2 out of 2 sampled residents (residents #1 and 2) to be placed with tied bedsheets around their torsos while seated in their chairs and due to the administrator allowing a hazardous environment in the facility which made 1 out of 4 sampled residents (resident #3) feel intimidated.

The findings are:

Review of the photographs submitted to this Agency by the complainant on indicated that residents #1 and 2 were seated in their respective chairs with bedsheets wrapped around their torsos and around each chair. Further review of the photograph with resident #1 who was sitting in the facility's living room, it displayed that the bedsheet that was wrapped around resident #1's torso and it also indented the cushion on the left side of the chair's cushioned . These photographs were submitted with this report for evidence.

In an interview with the complainant on at 3:15pm, he stated that when he was in the facility in the morning of , he saw residents #1 and 2 sitting in separate sofa chairs in the facility living room area, with bunched-up bedsheets tied around their torsos, with the knots placed towards the rear of their chairs. He stated that residents #1 and 2 presented to be physically incapable of untying the bedsheet knots on the rear of their soft sofa chairs by themselves so they may transfer out of their chairs if they so wanted. He stated that staff member A was the only facility employee caring for the residents in the facility when he arrived to the facility on and when he first observed residents #1 and 2 restrained in their chairs. He stated that the administrator arrived to the facility on at approximately 12:00pm, while residents #1 and 2 remained restrained in their chairs. He stated that he did not see staff member A or the administrator take action to remove the bedsheets from around residents #1 and 2's torsos while he was in the facility on . He stated that he took the photographs on to represent residents #1 and 2 were restrained while they were sitting in their chairs in the facility's living room area.

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In an interview with the administrator on at 1:05pm, she stated that staff member A was hired about 6 months ago and this employee worked a continuous shift in the facility from Saturday in the evening until Monday in the afternoon.

In an anonymous interview with an individual on at 1:15pm, he/she stated that he/she seen a staff member tie resident #1 to the sofa chair with a bedsheet while the resident was in the living room. He/she stated that the staff member would tie the bedsheet around the resident's waist occasionally for periods of time no longer than one hour, and it usually happened in the late mornings or afternoons. He/she stated that this form of resident was likely for the sole benefit of the staff member so the employee did not have to supervise the resident so closely shall the resident decide to get up out of the chair and walk towards the bedroom. He/she stated that although he/she had not seen the administrator actually tie the resident while the resident was in the chair, the administrator was aware of this restraining done by the staff member and the administrator did not act to prevent or discontinue the resident from being restrained. He/she stated that the administrator promoted this hazardous environment by verbally stating that the residents were prohibited to visit their own bedrooms during the daytime, even if the residents just wanted to take a nap in their own bed. He/she stated that the administrator continually perpetuated this intimidating environment in the facility and that resident #3 felt fearful and bullied by the administrator's demands to not allow the residents access to their own bedrooms in the daytime. He/she stated that if resident #1 was more competent and , aware of her surroundings, this resident would also likely feel fearful of being restrained and listening to the administrator's unreasonable demands.

In an interview with resident #1's daughter on at 4:00pm, she stated that since she lived close to the facility, she usually visited resident #1 about times per week. She stated that she had recently seen resident #1 with "folded-up" bedsheet on top of the resident's waist while sitting in the living room, and this bedsheet was not wrapped around the resident's chair. She stated that she did not know the exact reason why the facility staff would place this bedsheet on resident #1's waist and that she did not think much of it since it did not present to be a to resident #1 when she saw this. She stated that she was not aware if the facility staff tied a bedsheet around resident #1's waist when she was not in the facility. She stated that the facility staff did not ever discuss with her the option of physically restraining resident #1 at any time or to use the bedsheet to tie it around the chair so to restrain resident #1.

In an interview with the administrator on at 12:10pm, she stated that she was not aware of any residents in the facility to have been restrained. She stated that residents were susceptible to harm if they were restrained. She stated that she worked in the facility on from about 12:00pm to 7:00pm and that she did not observe any of the residents that day closely enough for her to determine

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that any of the residents were restrained. She stated that staff member A was on shift on before she arrived to the facility and that the staff member did not report any hazardous situation involving the residents to her. She stated that she was also aware that resident #2's bed had side rails installed for several months and that she did not remove the bed rail installed on the resident's bed. She stated that resident #2 was unable to use this bed rail on his own and would likely need the assistance of another person to use it.

Review of the facility's /neglect prevention policies and procedures did not have any instructions on how to reach the State of Florida prevention hotline upon suspicion or observed resident and/or neglect. Further review of this document indicated that there were no instructions to prevent resident or neglect and there were no procedures relating to the use of bed rails on resident's beds or other potential resident .

In an interview with resident #2's representative on at 10:10am, he stated that he had been to the facility about 3 times this last month to visit resident #2. He stated that the facility did not ever discuss with him the possibility or option to tie resident #2 in his chair for any reason whatsoever. He stated that resident #2 did not have any medical need to be restrained in any form.

Review of resident #1's record indicated that she was admitted to the facility on and she was diagnosed with and . Further review of the resident's health assessment dated on indicated that she had limited decision-making ability and she required physical assistance with ambulation and transferring.

Review of resident #2's record indicated that he was admitted to the facility on and he was diagnosed with and . Further review of the resident's record indicated that he was assigned a court-appointed guardian representative on .

Interview with residents #1 and 2's physician on at 1:20pm, he stated that he had examined residents #1 and 2 approximately 6 weeks ago and that the residents presented to be medically stable. He stated that he was familiar with the medical care for residents #1 and 2, and that the residents did not have any reason to be restrained or to be limited in their mobility or movements in any way. He stated that he never discussed the option to restrain any of the residents with the facility staff or any of the residents' representatives. He stated that residents #1 and 2 were because they both lacked the capacity to express their personal needs, resident #1 needed assistance with her mobility and resident #2 was an elopement risk.

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Class II

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation, interview and record review, the facility failed to adequately store 3 out of 5 sampled resident medications (residents #1, 4 and 5) by not keeping the medications locked in the medication cart at all times.

The findings are:

In an observation on at 11:05am, residents #1, 4 and 5's medications were stored on top of the medication cart located in the dining room of the facility. During this observation, residents # 2 and 4's medications presented to be accessible by any person who was inside the facility dining room.

In an interview with the administrator on at 11:10am, she stated that residents #1, 4 and 5's medications were being stored on top of the medication cart since these medications were duplicate medications received by the facility a couple weeks before. She stated that she was aware that these medications were accessible to any person who was inside the dining room and must be returned to the pharmacy where the medications were sent from.

In an interview with staff member B on at 11:20am, she stated that she had not received resident medication assistance training since and the administrator required her to assist the residents' self-administration of medication. She stated that she had access to the resident medications stored on top of the medication cart located in the dining room and she did not know where those medications belonged.

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 429.52( ),58A-5.019(1) FAC

Based on interview and record review, the facility administrator failed to provide adequate management of its direct care staff by not ensuring it was adequately trained and by the administrator not implementing actions to continually honor resident rights to prevent hazardous situations.

The findings are:

In an interview with staff member B on at 11:20am, she stated that in an event of potential or actual event of resident or neglect, she would report this event to the resident's social worker.

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She stated that after reviewing a resident's record, she would not know how to immediately reach a resident's social worker. She stated that she would report this event to the resident's family member first and then ask the family member what she needed to do next. She stated that she did not feel adequately prepared to handle a situation involving resident and/or neglect because the facility and the administrator did not train her on what to do when she was initially hired. She also stated that she had not received resident medication assistance training since and the administrator required her to assist the residents' self-administration of medication. She stated that she performed assistance with self-administration of medications for the residents during her continuous work shifts from Tuesday mornings to Friday evenings.

Review of staff member B's employee record indicated that she was hired on and that she did not receive any facility-specific resident rights or and neglect prevention training. Further review of this record indicated that the staff member last received a 2-hour assistance with self-administration of medication training on .

Review of resident #1's medication observation record dated from to indicated that staff member B assisted the resident with the self-administration of the resident's medications.

In an interview with the administrator on at 12:10pm, she stated that she was not aware of any residents in the facility to have been restrained. She stated that residents were susceptible to harm if they were restrained. She stated that she worked in the facility on from about 12:00pm to 7:00pm and that she did not observe any of the residents that day closely enough for her to determine that any of the residents were restrained. She stated that staff member A was on shift on before she arrived to the facility and that the staff member did not report any hazardous situation involving the residents to her. She stated that she was also aware that resident #2's bed had side rails installed for several months and that she did not remove the bed rail installed on the resident's bed. She stated that resident #2 did not have any physician order to have bed rails installed on his bed, the resident was unable to use this bed rail on his own and would likely need the assistance of another person to use it. She also stated that she was aware that staff member B needed a current and valid medication assistance training certificate to perform properly assist the residents in the facility and that she did not ensure the staff member received this training. She stated that she was not sure if staff members A and B received all the required orientation and training to fulfill their job responsibilities.

Review of resident #2's record indicated that there was no physician order to require the resident's use of bed rails on his bed.

Review of staff member A's employee record indicated that she was hired on and that she did

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not receive any facility-specific resident rights or and neglect prevention training. Further review of this record indicated that the staff member was required to immediately report to the administrator any hazardous situations and any resident incidents or accidents.

In an interview with the administrator on at 1:05pm, she stated that in an event of potential or actual resident or neglect, in which a resident presented to be restrained, she would immediately ask the staff member on shift to remove the bedsheet from around the resident's waist and she did not elaborate on taking additional steps to prevent a similar event from happening again. She stated that she was not familiar with the State's prevention hotline. She stated that she did not remember when she was last trained on resident and neglect prevention. She stated that she did not ensure that the facility's direct care staff receive up-to-date and neglect prevention training so to prevent any events that could place the residents in a hazardous situation.

Class II

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on record review and interview, the facility failed to maintain the personnel record for 1 out of 3 sampled staff member (staff member C).

The findings are:

In an interview with the administrator on at 10:55am, she stated that after looking for staff member C's employee, she was not able to locate and provide this record for review.

Review of the facility employee records, it was determined that staff member C's employee was not available.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation, record review and interview, the facility failed to prepare a detailed emergency environmental control plan to address the event involving the loss of primary electrical power in the facility during an emergency.

The findings are:

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In an observation on at 11:55am, there was a power generator inside the shed located on the south side of the facility property and there were 25 gallons of fuel stored inside the shed located on the south west side of the property. During this observation, there was no portable air conditioning unit stored in the facility.

In an interview with the administrator on at 12:00pm, she stated that there was no more fuel stored in the facility.

In an interview with the administrator on at 12:35pm, she stated that she believed that the emergency environmental control plan was included and approved along with the facility's comprehensive emergency management plan (CEMP.) She stated that she did not know the steps to safely maintain fuel at the facility to ensure there is sufficient fuel available to supply the power generator to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours, after the loss of primary electrical power in the event of an emergency. She stated at this time that she could not describe what life safety equipment the power generator will power, the square footage to be air conditioned and how the residents will be relocated to the air conditioned space during the event of an emergency. She stated that the portable air conditioning unit she intended to use in the facility during the event of an emergency was not presently stored in the facility.

Review of the facility's approved CEMP dated on indicated that the facility did not describe what life safety equipment and which air conditioning unit the power generator will power, the square footage to be air conditioned and how the residents will be relocated to the air conditioned space during the event of an emergency. Further review of this CEMP indicated that the facility needed to have 32 gallons of fuel immediately available to operate its power generator for 96 hours in the event of an emergency.

In an interview with the local emergency management agency planner on at 11:15am, he stated that the facility did not have an approved emergency environmental control plan or a related variance on file. He stated that the facility received information from his agency on indicating the facility did not have an approved emergency environmental control plan and the steps needed to submit this plan for review. He stated that his agency did not receive any additional information from the facility regarding its emergency environmental control plan.

Class III