STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943030	01/16/2019
NAME OF PROVIDER OR SUPPLIER **TREEMONT ON THE PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **3881 NE 3RD AVENUE** **OAKLAND PARK, FL 33334**	

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

0000 - Initial Comments

An unannounced abbreviated Relicensure survey was conducted on and at Treemont On The Park, License #8336. 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 interview, it was determined the facility failed to ensure the Health Assessment AHCA form 1823 was completed in its entirety, for 2 out of 2 sampled residents (Resident #6 and Resident #10).

The findings included:

1. A record review for Resident #10 found an admission date of . AHCA health assessment form 1823 dated documented the following diagnosis Unspecified without Behavioral Disturbance, Major , , Type II without complications. The AHCA form 1823 lack documentation if Resident #10 requires a special diet; Requires 24 hour nursing or , care; Requires medication administration and there is no date of examination.

2. Record review for Resident #6 who was admitted to the facility on. The 1823 form lacked documentation if the resident is free from communicable ; bedridden; has any , 3 or 4 ; pose a danger to self and others; and requires 24 hour nursing or , care.

During an interview with the Administrator on at 10:55 AM, the findings of the ACHA form 1823 was discussed regarding Resident #10 and Resident #6. The Administrator had no rebuttal but stated the resident's physician will complete the form in its entirety on the next physician visit.

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 that the facility failed to ensure that a resident was reassessed after a significant change and the health assessment (AHCA form 1823) was accurate and reflective of the resident's current condition and care needs, for 1 out of 1 sampled resident records reviewed (Resident #10).

The findings include:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943030	**01/16/2019**
NAME OF PROVIDER OR SUPPLIER **TREEMONT ON THE PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **3881 NE 3RD AVENUE OAKLAND PARK, FL 33334**	

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

Observations of Resident #10 on between the hours of 8:00 AM and 10:00 AM, revealed Resident #10 inside of her room and laying on the bed. An interview was attempted on when Staff A advised that the resident only smiles and is nonverbal. A hospice patient care aide came to the room and stated she was there to feed the resident. The Hospice Aide attempted to have Resident #10 feed herself twice but the resident was unable to hold her spoon and showed signs of . The hospice aide stated someone from the hospice agency come to feed the resident for breakfast, lunch, and dinner, as she cannot feed herself. On at 8:10 AM a staff member came inside of the room to assist with self-administration of medication. The Staff member had medication inside of the cup and also had a container of applesauce. The staff member mixed the medications together with applesauce and administered the medication to the resident. The staff member advised that Resident#10 cannot hold her spoon nor can she feed herself and further stated, "We have to do these things for her".

Record Review of Resident #10's file revealed an admission date to the facility on . Review of the Resident Health Assessment form dated 11/08/16, documented the resident diagnosis as , Dyslipidemia and . The Nursing Services section of the form listed hospice and the section documented status and medication management, the ADL section of the 1823 stated the resident required assistance with ADL care.

During an interview with the Administrator on at 11:02 AM,The Administrator stated that he was unaware of his staff members administering medications to Resident #10. The Administrator further stated that he is aware the resident was total with all levels of ADL care. The Administrator stated that he had her 1823 updated to reflect hospice but did not notice the column for total care. The Administrator confirmed the findings of not having an updated 1823 reflective of the resident current health care needs and significant change. The Administrator also acknowledged that it is out of the scope for his staff to administer medication, as he does not have any nurses employed at the assisted living facility.

Class III

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

Based on interview and observation, the facility failed to ensure residents were free of physical (full bed-rails) for a sample of 2 out of 3 sampled residents (Resident#6 and Resident #8). The facility also failed to honor resident rights of dignity due to using a as a bib and tablemat during meal times (Resident#5 and Resident #10).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943030	**01/16/2019**
NAME OF PROVIDER OR SUPPLIER **TREEMONT ON THE PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **3881 NE 3RD AVENUE OAKLAND PARK, FL 33334**	

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

The findings included:

1. During an initial tour of the facility on , it was noted that Resident #6 & #8 had full bed rails attached to one side of the bed, the bed was in the down position. An interview was immediately conducted with Staff A. Staff A stated that Resident #8 had been residing at the facility for about 6 months and she is always getting out of bed. Staff A stated the full bed rails go up every night to prevent her from getting out of bed at night time. Staff A stated that sometimes, when she works on the second shift, she also puts the bed rails up to ensure the resident stays in bed. Staff A further stated, Resident #6 has always had full bed rails since she moved into the facility a few months ago. She further stated, that Resident #6's full bed rails go up every night to prevent her from out of bed. Staff stated that both residents are unable to control the bed rails themselves and must always wait for staff to put the bed rails down to come out of the bed.

An interview with Resident#6 was attempted on at 10:02 AM, however the Resident#6 was showing signs of being extremely .

An interview with Resident#8 was attempted on at 10:02 AM, however the Resident #8 was showing signs of being extremely .

2. During lunch observations on at 11:35 AM, it was revealed that Resident #10 required total assistance to be fed. Staff A stated that hospice comes every day to the facility to feed four residents breakfast, lunch and dinner. A hospice employee arrived to the facility at 12:01 PM. The Hospice employee requested food for the resident and began to prepare to eat. The Resident was observed in a supine position and was positioned to sit upright. The Hospice employee took two pads out of the box that stated " pads" and placed one on the resident's and the other went underneath her plate of food. Breakfast observations on revealed the hospice employee returned to the facility at 7:55 AM to feed Resident #10. The hospice employee went inside of the room and began to prepare the resident to eat breakfast. The hospice employee was observed again taking two pads out of the bag and placed one of the pads on top of the resident's and using the other as a tablemat placing the resident's spoon on top if it and her bowl of oatmeal.

An interview was conducted on with the hospice employee. The hospice employee stated that every day she comes to the facility, she has the same routine with this resident. It was further stated that she brings the pads with her and uses them for all the of the residents that she feeds as a bib and a table placement mat.

An interview was conducted with Staff A who also accompanied the hospice employee and observed

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943030	01/16/2019
NAME OF PROVIDER OR SUPPLIER **TREEMONT ON THE PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **3881 NE 3RD AVENUE** **OAKLAND PARK, FL 33334**	

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

Resident#10 being fed with the , on her and underneath the bowl of oatmeal. Staff A confirmed that this is hospice's everyday routine on feeding the resident.

An interview was conducted on at 10:47 AM with the Administrator. The Administrator advised that he does not have a full bed rail order for both residents and was unsure why the full bed rails were on the resident's bed. Further questioning revealed that the Administrator placed the full bed rails on both residents bed himself. The Administrator stated that he would have the rails removed and place ½ side rail on the bed when he obtain a physician order. No further explanation and documentation was given during the survey regarding this matter.

Class III

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

Based on observation, record review and interviews, the facility failed to ensure that 1 of 29 residents (Resident #6) was identified as an elopement risk and followed the minimum steps for residents at elopement risk.

The findings included:

During a review of Resident #6's health assessment dated (admission date unknown), it was noted that the resident was at risk for elopement. This identification was indicated on the bottom of section I of the form. The record also revealed that the resident was assessed on by a healthcare professional as having the following diagnoses Unspecified w/o behavioral disturbance, major , , type II w/o complications. Observations on and between 10 AM and 1PM revealed that the resident did not have on her person any special method of identification .

During an interview with the Administrator on at 10:13 AM, he acknowledge that he did not put any identification on the resident's person and confirmed the findings.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observation, interview and record review, the facility failed to follow the proper procedure for providing assistance with self administration of medication, for 1 of 5 Residents reviewed (Resident # 9) observed during the med-pass.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943030	**01/16/2019**
NAME OF PROVIDER OR SUPPLIER **TREEMONT ON THE PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **3881 NE 3RD AVENUE OAKLAND PARK, FL 33334**	

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

The findings included:

On at 11:49 AM, a medication observation was conducted with Staff A Home Heath Aide (Unlicensed Staff). Staff A sanitize her . She took out the Medication Observation Record (MOR) failed to compared the medication to the MOR. She poured the residents medication into a cup. She took the water and pills to Resident # 9. She did not verified the name of the resident and announced "Here are your afternoon meds". She failed to identify each medication. She then watched the resident swallow the pills and returned to sign the MOR.

On at 11:52 AM, immediately following the medication observation. Staff A were advised that the unlicensed staff is required to sanitize her , verify the medication with the MORs and announce the name of each medication prior to assistance with self-administration of the medication. Staff A stated she was nervous, and she knows that the resident has .

On at 8:10 AM, a medication observation was conducted with Staff D, a home health aide (unlicensed staff). Staff D sanitized her , took out the medication, took the medication to the kitchen, advised that she would use a can opener to crush Resident #10's medication because they don't have a pill crusher at the moment. The can opener was rubbing against a filled garbage can in the kitchen, Staff D took the can opener attached onto the table and hit the pills with it. The can opener burst the pill container and broke 2 of the 3 pills in half. Staff D proceeded to the resident room with a container of applesauce. Staff D mixed the medication with the applesauce and administered all of the medication to the resident

On at 8:10 AM, an interview was conducted with Staff D. The staff member advised this is the way they have to do it for Resident #10 because she cannot do it for herself. Staff D confirmed again at this time, that they don't have a pill crusher onsite to crush medication for residents. Staff D further stated that she was a little nervous and that's why she didn't say the name of the pill and she also knows the resident won't have any idea what she is saying to her.

Class III

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

Based on record review and interview, the facility failed to obtain at minimum, documentation of high

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943030	01/16/2019
NAME OF PROVIDER OR SUPPLIER **TREEMONT ON THE PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **3881 NE 3RD AVENUE** **OAKLAND PARK, FL 33334**	

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

school diploma or equivalent for the facility Administrator.

The findings included:

Record review of the Administrator's file (hire date was), revealed no documentation of a high school diploma on file. Further review revealed no documentation of any higher level education and/or any education equivalent to a high school diploma . Further review revealed the Administartor did not have a job description on file. At this time, the Administrator was provided the opportunity to locate the documentation.

During an interview on at 2:00 PM with the Administrator, he acknowledged the findings and provided no additional documentation for review.

Class

0083 - Training - First Aid and - 58A-5.0191(5) FAC

Based on employee record review, staffing schedule, and interview, the facility failed to ensure 3 out 3 staff members has a completed course in First Aid and holds a currently valid card documenting completion of such courses (Staff A, Staff B and C).

The findings include:

During the employee record review, it was noted that Staff A (hire date) works 6am -2pm shift, Staff B (hire date) works 2PM -10 pm shift and Staff C (hired on) works 10pm - 6am shift. Further review revealed there was no documentation contained within the employee's file, showing Staff A, B and C completed an approved course in First Aid and hold a currently valid certification card.

Review of the facility's staffing schedule for Staff A, B and C revealed they both work various shifts and neither hold a valid certification card for First Aid and . Staff A, B and C are not a licensed nurse or an Emergency Medical Technician/Paramedic. The Administrator was given an opportunity to present a valid / First Aid card and was unable to do so.

During interview conducted with Administrator and Consultant on at 2:00pm, he

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943030	01/16/2019
NAME OF PROVIDER OR SUPPLIER **TREEMONT ON THE PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **3881 NE 3RD AVENUE** **OAKLAND PARK, FL 33334**	

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

acknowledges the absence of documentation confirming completion of the First Aid and training.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC 429.52 (6), FS

Based on record review and interview, the facility fail to ensure that all staff members who pass medication had completed a total of 6 hours of training regarding medication practices; specifically to the new rule, for 2 of 3 staff members (Staff B & C).

The findings included:

During a record review for Staff B, the 6 hour medication training could not be located within the file. Further review revealed an initial 4-hour training dated . No further training could be located within the file.

During a record review for Staff C the 6 hour medication training could not be located within the file. Further review revealed an initial 4-hour training dated . No further training could be located within the file.

During an interview with the Administrator on , he confirmed that all Staff members (unlicensed) give medication to all of the residents. The Administrator advised that he was unaware of the new rule requiring 6 hours of medication training (initial training or an additional two hours for staff hired before the new rule. The Administrator provided no further documentation at the time of the survey.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview, it was determined that the facility failed to ensure that all staff members received 1 hour of training on the facility's policy and procedure regarding ( ), for 1 out of 3 sampled staff records reviewed (Staff B).

The findings include:

Record review revealed that Staff B was hired at the facility of . Further review revealed the file lacked documentation indicating completion of 1 hour of training in the facility's policy and procedure

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943030	**01/16/2019**
NAME OF PROVIDER OR SUPPLIER **TREEMONT ON THE PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **3881 NE 3RD AVENUE OAKLAND PARK, FL 33334**	

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

regarding within 30 days of employment. A review of the facility staffing schedule for the week of - revealed that Staff B works Sunday - Wednesday, 2:00 PM - 10:00 PM.

During an interview conducted on at 2:30 PM, with the Administrator, he confirmed the findings.

Class III

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

Based on observation, interview and record review, the assisted living facility failed to ensure the facility's approved menu by a dietician, was followed at all times for 29 of 29 sampled residents. As evidenced of the facility not serving or substituting items of comparable, nutritional value for menu items. The facility also failed to maintain a 3-day supply of nonperishable food that must be kept on at all times for 29 of 29 sampled residents who eat orally and reside at the facility.

The findings included:

a) A review conducted on of the facility's posted dietician approved lunch menu for revealed the menu to reflect the following items: 3 oz meat sauce, ½ cup of spaghetti, ½ cup of broccoli, ½ cup of tossed salad/ , 1 slice of bread/ margarine, ½ c pineapple and a 8 oz beverage.
In an observation conducted on at 11:38 AM, the lunch served to the residents consisted of the following items: Meat Sauce, spaghetti and tossed salad. The chef did not serve a ½ cup of broccoli, 1 slice of bread and a ½ cup of pineapple. No other alternative for comparable nutritional value were offered to substitute the missing menu items

A review conducted on of the facility's posted dietician approved breakfast menu for revealed the menu to reflect the following items: French toast, Syrup, Bacon, Margarine, Fruit Juice, Milk/Coffee, Tea. In an observation conducted on at 8:00 AM, the breakfast served to the residents consisted of the following items: A bowl of Oatmeal and Coffee. No other alternative for comparable nutritional value were offered to substitute the missing menu items.

On at 12:01 PM, an interview was conducted with the chef. The chef stated she did not have pineapple, bread or broccoli to serve the residents so she cooked what she had. The Chef admitted to

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943030	01/16/2019
NAME OF PROVIDER OR SUPPLIER **TREEMONT ON THE PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **3881 NE 3RD AVENUE** **OAKLAND PARK, FL 33334**	

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

not communicating with the Administrator that they did not have some of the food items listed on the menu. On at 8:30 AM, Staff D stated they did not have French toast or bacon so instead she only served the oatmeal and thought that was enough for them.

On at 10:09 AM an interview was conducted with the Administrator to inform him of the findings for lunch on and breakfast on . The Administrated stated he was not aware of the food menu items needing replacement. The Administrator stated that he has been struggling to find a good chef and that he is still looking for a chef. No further explanation provided at the time of the survey.

b) On at 9:30 AM, observations of the ALF emergency food supply revealed three 40 oz bags of cake mixes and two 20 oz bags of sugar free butterscotch pudding.

On 01/1619, a record review of the facility's disaster menu lists items such as assorted juices, canned meats, canned vegetables, canned fruits, canned soups, assorted crackers, assorted cookies, and canned milk. Observations of the emergency supply of food did not reflect items listed on the current approved disaster plan menu dated for year of 2018 - 2019.

On at 9:35 AM, the Administrator stated he had just taken out all of his hurricane food supply and put it in the kitchen due to some of the food items expiring soon. The Administrator further stated that hurricane season was over and that he would have restock the hurricane supply on his next food order. On at 9:35 AM, the Administrator acknowledged the findings. The Administrator also confirmed the facility census is 29 and that their is not a sufficient supply of nonperishable food/emergency supply.

On at 9:45 AM the Administrator was informed there is no posted menu. The Administrator stated there is a posted menu in the courtyard. The surveyor ask the Administrator to point out the posted menu in the courtyard. The Administrator and the surveyor walked to the exterior dining room door where there is a bulletin. The bulletin only had a posted activities schedule. The Administrator replied I posted it, someone must have taken it down. The surveyor advised the Administrator the menu was not posted on (Day #1 of survey) nor (Day #2 of survey). The Administrator confirmed the findings and provided no further explanation.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943030	**01/16/2019**
NAME OF PROVIDER OR SUPPLIER **TREEMONT ON THE PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **3881 NE 3RD AVENUE** **OAKLAND PARK, FL 33334**	

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

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and interview, the facility failed to have an approved omprehensive Emergency Management Plan (CEMP) from the local County Emergency Management Division.

The findings included:

On at approximately 9:30 AM, the CEMP was requested from the Administrator. The Administrator advised that he had no recollection of submitting a CEMP to the local County Emergency Management Division or receiving an approved CEMP from the County. The Administrator kept referring to the approved generator plan, confusing it with the CEMP. The Administrator also stated that he did not have documentation of the most recent approved CEMP to provide for review.

Unclassified