STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942934	**01/24/2019**
NAME OF PROVIDER OR SUPPLIER **GRAND COURT ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **295 SW 4TH AVENUE POMPANO BEACH, FL 33060**	

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

0000 - Initial Comments

An unannounced licensure Complaint Survey CCR# 2018015493 and 2018018042 was commenced on and concluded on at Grand Court ALF, License #5464. The facility had deficiencies identified at the time of the visit.

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

Based on observation, record review, and interview, the facility failed to provide care and services appropriate to meet the needs of the residents accepted for admission to the facility, for 3 out of 3 sampled residents (Resident #1, Resident #2, and Resident #3). As evidenced of the facility failing to provide adequate supervision to prevent and adequate staffing to prevent elopement for all sampled residents (Resident #1, Resident #2, and Resident #3) residing at the facility.

The findings included:

During an interview with Resident #3 on at 11:00 AM, it was stated that when I call no one comes at night and that the call light does not work. When you pull it, you wait for hours and hours and no one comes to help or check on you. The resident stated that I cannot walk and I need help getting in and out of the bed from staff. It was further stated that there is a on my bottom from staff not transferring me properly and that my bottom is always scrapping against the chair. Resident #3 stated that the facility is short staffed and that there isn't enough staff to care for them. No one comes when the emergency light is pulled, and that I keep falling. The resident showed the surveyor her injured . Observations of the revealed white bandage to an injury that had happened recently. Additional interview with Resident #3 during this time at 11:00 AM on revealed that Resident #3 had out of bed trying to turn over and reposition herself and first with her arms out in an attempt to break the . Resident #3 stated that she had been there for a long time and no one came. The resident could not remember that date of the incident in which the occurred.

The Surveyor pulled the Emergency call light at 11:05 AM on that was located behind the resident's bed. At 11:20 AM, facility staff still had not come into the room.

During an interview with the Corporate Personnel at 11:25 AM on that was standing outside of the room when the emergency light was pulled stated that I did not hear anything from the staff about there being an emergency in Resident #3's room, and that I will have maintenance look at it.

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Confidential Family and Resident interviews on between the times of 9:00 AM and 5:00 PM revealed that residents all of the time, and that staff is not around to assist anyone when they need help. It was also revealed that there have been multiple occasions in which residents lock their room doors at night, and unable to receive assistance from staff until the morning shift comes in at 6:00 AM. One resident stated that every time he calls for assistance at 6:30 AM to get out of bed, no one comes and that he often has to wait in his bed even when he has to use the bathroom. The resident further stated that on weekends it is even more difficult to get assistance.

Review of the Health Assessment (AHCA 1823 form) for Resident #3 dated for revealed that Resident #3 is alert and oriented times three, is documented to be a precaution, and that the resident requires assistance with all Activities of Daily Living (ADL's) except for eating.

During an Interview with the Director of Nursing (DON) at 2:00 PM on , revealed that some of the call lights are not working and at night there are 4 aides in each section. It was further stated that at night there is a supervisor here until 11 pm and after that the CNA's is here by themselves. After 8pm no one is at the front desk. It was further stated that the CNA's are supposed to do rounds every 2 hours in their section to check on the residents. It was stated that there are cameras to observe that the CNA's re doing their rounds. The shift for the med techs are from pm and at 8pm comes the other 4 CNA's.

The facility's staffing schedules for direct care staff for the Months of through , was requested for review. Throughout the survey, all 4 months for Care staff was never provided to verify that the facility had enough staff to meet the care needs of all of the residents.

During an interview with the Administrator at 2:20 PM on , it was stated that all of the call lights in the facility was is working properly and that even if they are not the staff check the residents every 2 hours. The Administrator could not provide anything in writing that verify that the staff are actually checking the residents. The Administrator also could not provide any policy or procedure put in place that states the residents are to be checked every two hours, or who is to check the residents. The Administrator could not provide any information to the location of staff on any given day with cameras in place as to the reason so many residents are falling with no adverse incidents being completed to those that has needed medical attention due to the lack of supervision in the facility. The facility failed to put in place a system to ensure the safety and supervision of the residents and failed to implement a system to ensure that the procedures set fourth are effective.

During an interview with the Administrator, the DON, and Corporate Personnel on at 3:00 PM, the findings were discussed and acknowledged, no further information was provided for review.

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B. Interview from a Confidential source on at 9:46 AM revealed verified evidence that Resident #1 has eloped from the facility more than once since being admitted on .Review of the first AHCA 1823 form provided for Resident #1 dated for revealed a medical history and diagnosis of , and a and behavioral status that states has periods of disorientation, believes he still works, and special precautions states . The resident is independent with all ADL's except for bathing in which the resident requires supervision. The form has no documentation that resident is an elopement risk. And it is also marked yes when asked does the resident require 24 hour nursing supervision. Review of the signature lines on the of the form acknowledging receipt and accuracy revealed that the administrator never signed Resident #1's 1823 form.

Review of the second AHCA 1823 form for Resident #1 provided and dated for revealed a medical history and diagnosis of , and that the resident is on precautions. The resident is identified as an elopement risk. During an interview with Resident #1 on at 11:15 AM, it was revealed that the resident is not alert to place and time, and displayed exit seeking behaviors thinking that he still had to go to work when needed. Observation of the resident during this time revealed that the resident is being kept amongst the general Assisted Living population in the same general areas where he eloped multiple times in the past.

Additional observations throughout the Survey on revealed periods of times when there is no one sitting at the front desk when the receptionist is called away to assist others. The front doors of the facility is locked with the same system in place that the resident used to get outside of the facility the previous times the resident eloped with the most recent occurring on .

Review of the progress notes for Resident #1 dated for revealed that the resident was reported missing by an unspecified facility staff member. On the resident still had not been found and it was reported to the local police. The resident was found later in the day on and was taken to the hospital for evaluation. The resident was returned to the facility on . Another entry dated for revealed a progress note stating that the resident returned to the facility from the Hospital from having an Elopement.

With cameras in place, no one can determine the location of staff during both incidents. No adverse incidents, incident reports, or care plans was put in place to ensure that the resident is properly supervised to prevent future elopements, or to monitor the residents general whereabouts and wellbeing while inside the facility. The facility took over a year to get a new 1823 form documenting the significant change in the resident in which the resident was never reassessed to determine appropriateness even after the most recent elopement that occurred involving law enforcement

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During an interview with the Administrator at 12:36 PM on the findings were discussed and acknowledged, no additional information was provided during this time for review.

C. Confidential resident interview on between the times of 9:00 AM and 3:00 PM revealed that Resident #2 out of the bed when the staff was turning her to transfer her from the bed to her wheelchair. It was stated that there should have been two people but there was only one because there is not enough people here. It was stated that the Staff here are not trained the right way on how to transfer us and that's why we keep falling. It was stated that when Resident #2 she was telling the Staff 'I am falling' as she was going down but the staff member was alone and could not stop the .

During an interview with the Administrator at 12:28 pm on , it was stated that Resident #2 went to the hospital on and then went for rehab. When questioned regarding the reason for Resident #2 going to the Hospital it was stated that I don't know, it would be in the chart.

Review of the file for Resident #2 revealed an AHCA form 1823 dated for . Review of the form revealed a medical history and diagnosis of , , meningioma, frequent , and unsteady gait. The resident is alert and oriented times three, and independent with all activities of daily living (ADL's) except for bathing and toileting in which the resident requires assistance. Review of the progress notes dated for at 6:00 AM revealed the resident out of bed attempting to transfer to her wheelchair by herself and that the roommate of the resident called the staff for assistance when the roommate found the resident on the floor. The resident was transferred to the local Hospital for evaluation and treatment and was to follow up. No further documentation was written where the facility followed up on the resident.

During an interview with the Administrator, the DON, and the Corporate Personnel on at 3:00 PM, no information could be provided on why the resident was never reassessed for a significant change for or why the facility never put any policies and procedures in place to provide supervision to the resident due to her 1823 form stating that she has frequent and an unsteady gait. The 1823 form was determined to be inaccurate of the residents current care needs and the facility failed to provide adequate supervision to meet Resident #2's care needs to prevent . During this time, the findings were discussed and acknowledged. No further information was provided for review.

Class III

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0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to provide a living environment free of hazards and ensure that all structural systems, and appurtenances are maintained in good working order for all sampled residents.

The findings included:

Tour of the facility with The Corporate Personnel at 10:00 AM on revealed the following:

a) Observations of the brown vinyl floor in the memory care unit revealed tan and black colored markings throughout the entire unit that resembled stains and scratches. Observations of the scratched-like markings further revealed the wood-like material underneath. The floor was dull and dirty even when mopped and cleaned.

b) Observations of revealed multiple holes in the wall behind the resident's bed. One hole was observed where the bottom railing of the bed was into the wall causing a hole large enough for a to easily fit through. Additional observations revealed deep scrapes in the wall next to the bathroom door where an additional hole was found nearly the size of a golf ball. Observations of the inside of the residents door knob to enter and exit the room revealed that the surrounding piece that attaches the door knob to the door had come off and was now hanging loosely. The residents shower chair in the bathroom of the residents room revealed that the screws holding up the of the chair had come off, and the of the chair was hanging loosely. The Shower chair posed a safety hazard for the resident if leaning in the chair the resident will while in the shower.

During an interview with Resident #4 at 10:47 AM revealed that the staff comes in all the time and have seen the wall. None of the staff that assist Resident #4 reported the damages to the chair.

During an interview with the Maintenance personnel on at 10:48 AM, it was stated that it will be fixed and it has not been reported to have been repaired. During an interview with a confidential source revealed damage wall has been in that condition for months. The Corporate Personnel was shown the things in the room for repair.

During an interview with the Administrator at 3:00 PM on , the physical plant findings were discussed and acknowledged. No further information was provided for review during this time.

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