STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965625	**03/21/2019**
NAME OF PROVIDER OR SUPPLIER **ACTIVE SENIOR LIVING RESIDENCE**	STREET ADDRESS, CITY, STATE, ZIP CODE **9057 NW 57TH STREET** **TAMARAC, FL 33321**	

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

0000 - Initial Comments

An unannounced Relicensure Survey was conducted on . . . . . through . . . . . at Active Senior Living Residence, License #9969. The facility had deficiencies identified at the time of the visit.

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

Based on record review and interview, the facility failed to ensure that all residents had an Agency for Health Care Administration Resident Health Assessment (AHCA form 1823) that was reflective of the resident's current diagnosis, for 1 of 4 sampled residents (Resident #6).

The findings included:

Review of the file for Resident #6 on revealed Hospital discharge instructions dated for . . . . . revealed that Resident #6 has a medical history and diagnosis of type 2 . . . . . amongst other medical conditions. Review of the 1823 form dated , revealed that the diagnosis was not listed on the form.

During an interview with the Administrator, the Manager, and the Regional Director on . . . . at 3:30 PM, the findings were discussed and acknowledged. No further information was provided for review.

Class III

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

Based on interview and record review, it was determine the facility failed to document and resolve residents' grievances. As evidence of residents making numerous complaints about changes they wanted to see inside of the facility.

The findings included:

During numerous confidential interviews conducted on . . . . . through . . . . . between 9 AM and 3 PM, residents stated they wanted to see more of a variety in activities and they were tired of having bingo and sittercise all the time. The residents stated in the past two months they have voice numerous complaints to the Manager and the Administrator; they are slowly responding to resolve their concerns.

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SUMMARY STATEMENT OF DEFICIENCIES
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Record review revealed the facility had a grievance book documenting residents' grievances. However, the last grievance that was documented was , . The grievance policy was requested from the facility but could not be provided. Therefore, the facility was unable to demonstrate that they are following the facility's grievance policy and procedure regarding receipt and resolution of complaints/concerns.

On at 3:05 PM, an interview was conducted with the Manager and Administrator regarding the grievance process. The Manager stated that the residents usually come to her office regarding all the of grievances and concerns that they have. She further stated that she usually receives all verbal grievances and try to resolve them right away. The Administrator who was present for the interview stated, one of the grievances they received regarding activities has already been resolved, hiring a new activity director and revamping the activity calendar with more variety in activities. The Administrator and the Manager both acknowledged they were receiving numerous grievance request from the residents yet failed to document receiving and resolving the grievances.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation, record review and interview, the facility failed to maintain adequate staffing hours to meet the care needs of all residents (Resident #1-#59) residing in the facility and as required for a census of 59.

The findings included:

During confidential resident interviews conducted on through between 9:00 AM and 5:00 PM, the following was revealed regarding staffing concerns. It was revealed that on weekends there are no staff inside the facility to assist residents with care and that when they walk around to look for someone, no one can be found. It was stated by multiple residents that while waiting on someone to assist them to the bathroom; they go on themselves and have to sit there until someone finds them.

Review of the clock in/out time sheet hours revealed that there was only 1 staff (Staff C) working in the facility for the entire building on Friday and Saturday on the night shift (10:00 PM-6:30 AM). During an interview with the Manager and the Administrator at 3:00 PM on , it was stated that the staff member (Staff E) that was supposed to come in that night never came in for night shift and it was too late to get that shift covered.

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

Review of the facility's time sheets and staffing schedule revealed discrepancies regarding the assigned shift for Staff E. Staff E, the staff member that Management indicated during interview that was verbally asked to work the night shift on . . . . . and . . . . . , worked her assigned shift for the morning shift that day (7:00 AM -2:00 PM) as noted per the schedule. Review of the staffing schedule for this time period provided no indication that any additional staff were assigned to work during the night shift (during the shortage) and that Staff E was ever assigned to the shift as previously revealed during interview.

During confidential interviews conducted with facility staff members on . . . . . between the times of 9:00 AM and 5:00 PM, the following was revealed regarding aforementioned incident. It was confirmed that only 1 staff member (Staff C) worked those nights and that no one came in. It was further stated that the Manager was notified, that no additional staff came in and that no management staff found additional coverage for those shifts. Additionally, it was stated that during the night shift, the staff was able to change and care for most of the residents at least once that night, but was unable to get to all of them. It was further stated that it was hard to supervise everyone, especially the residents that don't sleep in memory care and . It was further confirmed that during break times, the residents at the facility was left unattended, and alone in the event of an emergency. It could not be determined if the sole staff member stayed in the building during the breaks .

During an additional interview conducted with the Administrator and the Manager on at 10:23 AM, the following information was provided regarding an additional person present. It was stated that the Supervisor for the 6:00 PM to 10:00 PM shift was at the facility Friday night and that he stayed and slept at the facility overnight when he saw that no one else was coming. It was further stated that the Supervisor did not tell anyone, so there was no way for us to know ahead of time. During the interview, the Administrator confirmed that the Supervisor provided no care and services to the residents and acknowledged that Management staff was notified of the insufficient staff, and provided no additional coverage. The findings were further discussed, no additional information was provided for review.

Class III