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	AL11911234	03/12/2019
NAME OF PROVIDER OR SUPPLIER **BETHESDA ON TURKEY CREEK**	STREET ADDRESS, CITY, STATE, ZIP CODE **2800 FORDHAM ROAD, NE** **PALM BAY, FL 32905**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

Complaint investigations #2018018475 and #2019000507 were conducted on and . Bethesda on Turkey Creek Assisted Living, license #4788, had deficiencies related to both investigations 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 did not obtain a complete and accurate Resident Health Assessment form (AHCA form 1823) for 1 of 14 sampled residents (#13).

Findings:

Resident #13 had a health assessment dated that listed diagnoses of , , high , and . Section 1 letter A, of the assessment under the "T" for total care. The report indicated the resident was total in ambulation. There was a letter "A" under the T column for bathing, , grooming, transferring and toileting. There was a letter "I" under the same column for eating. The assessment did not clearly indicate what the resident's needs were in relation to his ability to perform his activities of daily living.

In an interview with the administrator on at 3 PM who said he overlooked the form.

Class III

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 to meet the needs for 8 of 17 residents sampled, and did not: 1) monitor residents for safety or changes in condition (#14), 2) provide regular assistance with activities of daily living (#6), and 3) maintain a written record of significant change or illness that required medical attention or the provision of additional services, or notification of the healthcare provider and family (#3, #4, #6, #13,#15, #16 and 317).

Findings:

1. Review of the closed record for resident #14 revealed she was admitted on . Her health assessment, dated , documented diagnoses which included and paranoia, and at risk for . She was independent with ambulation, grooming, toileting & transferring and required

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assistance with bathing, [redacted] and eating. She required assistance with self-administration of medications. She was living in [redacted] on the basement level of a resident hallway remote from the center of the facility. There were no call lights outside the room and just the one emergency pull cord in the room by the bedside. Notes indicate in [redacted] she was experiencing episodes of [redacted], and reported to staff on [redacted] that she had [redacted] out of bed the night before. She complained of a [redacted], was sent to the emergency room and returned the same day. On [redacted], notes document the resident was heard yelling for help during morning rounds, and found on the floor. The resident reported she had [redacted] at 8pm the night before when cleaning up after her dog, and no one had come all night when she called for help. She was unable to reach the pull cord. The staff called 911 and she was sent to the hospital. Her room was located in a section of the facility which was not routinely monitored during the night. The resident was officially discharged on [redacted].

On [redacted] at 1:00PM, the administrator stated resident #14 staff were not aware this resident did not sign the "waiver" that some of the some families in that section sign to state they do not want 2 hour checks throughout the night for their family member. He stated most residents in this section were more independent and did not need as much care.

2. On [redacted] at 11:45AM, resident #6 was observed sitting in a recliner in her room. She had family visitors, but agreed to be interviewed. She stated she required assistance with a shower and there was a schedule to get a shower 4 times each week. She said "I'm lucky if I get 1 or 2 showers a week." Review of the record for resident #6 revealed the most recent 1823 was dated [redacted] and included diagnoses of [redacted], type 2, [redacted] lower extremity lymphedema. She was wheelchair bound. She required supervision with bathing.

On [redacted], there was a note from the ARNP that resident #6 had not had a shower in over a week.

Review of the facility "shower log" for [redacted] found each day listed the residents scheduled for a shower, and a place to document if the shower was Taken or Refused. Resident #6 appeared in the log on [redacted] and [redacted]. On [redacted] "taken" was circled and the name of the caregiver was printed next to her name. No other dates that week had any circles or comments.

On [redacted] at 1:00 PM, the Director of Nursing reviewed the shower log and confirmed there was no documentation of showers given to resident #6 from [redacted]/19, except for one shower on [redacted].

3. On [redacted] at 11:45AM, resident #6 stated she received assistance with her medications, including [redacted].

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Review of the record for resident #6 revealed the most recent 1823 was dated and included diagnoses of , type 2, lower extremity lymphedema. She was wheelchair bound. She required assistance with self-administration of medications. Resident #6 was on a for Novalog , three times a day before meals. On at 4PM, her measurement was 295. The documented to give 6 units of Novalog for levels of 251-300. The MOR for at 4pm documented resident #6 was given 4 units of Novalog for a level of 295.

On at 1:40PM, the Director of Nursing confirmed the finding

4. On at 1:00PM, resident #3 was interviewed. She seated in a chair in her room. She stated she had a on her and would be having surgery soon to remove it. She said she was in the hospital around Christmas time and thought she had an .

Review of the record for resident #3 found a health assessment (form 1823) dated and signed by the hospital physician. There were no notes in the record indicating that the resident went to the hospital or why, and if her physician or family were notified at the time. There were no notes documenting her return to the facility.
On at 12:15pm, the Director of Nursing confirmed the finding.

5. During a tour of the facility on at 11:00AM, resident #4 was listed as a resident in the memory care unit, and reported to receive Limited Nursing Services (LNS) for , stockings. She was not seen in the unit. Her room contained an compressor, but there was no tubing or seen in the room. When asked, staff reported that resident #4 goes out into the main facility during the day and just comes into memory care to sleep. The caregiver stated resident #4 was recently moved to memory care because she at night. Further observation found resident #4 in the dining room at lunchtime eating her lunch with other residents. She was not wearing , stockings at the time of the observation.

Review of the record for resident #4 revealed she was admitted on . Her most recent 1823 was dated and documented diagnoses that included , memory loss, , and . She was not an elopement risk. She had an order for per as needed, and , stockings to be placed on in the morning and removed at bedtime. Further review of the LNS notes revealed the last day resident #4 was documented to have worn , stockings was . There was no documentation the physician was notified. On at 12:15pm, the Director of Nursing confirmed the finding.

On at 9:45AM, the administrator stated they let resident #4 come out of the memory care unit

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during the day, since she "just at night." He stated she likes to be outside, so we let her sit on the front porch during the day.

Review of elopement risk list provided by administrator on at 10:00 AM documented resident #4 was listed as an elopement risk. The administrator confirmed this on at 10:00AM.

6. The administrator provided copy of a fax send to 4 healthcare providers on to inform them residents experienced and meals were served in their rooms and the Health Department was aware. The fax listed residents # 13, #16 and# 17.

Resident #17 had a health assessment report dated that listed , high and ( ) and post- stress ( ). She was independent with her activities of daily living and needed assistance with medications.

Resident #13 had a health assessment dated and sleep .

Resident #16 had a health assessment dated that listed , high and .

The individual resident records review revealed no written notations regarding , and or how the residents were monitored to ensure the residents did not developed further complications.

In an interview with the director of resident care who said there were no additional notes.

7. Resident record review for resident #15 revealed a health assessment report dated that listed diagnoses high and and . She needed total care with activities of daily living and was under hospice care.

A facility note dated that indicated at approximately 9:30 AM she complained of . The saturation was 46% while on room air. was applied at 5 liters per minutes and the saturation was 65-70%. Unable to contact healthcare provider, 911 was called. The review revealed no evidence of a healthcare provider's order for .

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In an interview on at 3:30 PM with the med tech, she assisted with the survey, who was unable to locate an order for the .

Class III

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

Based on observation and interview, the facility failed to ensure medication carts were locked and secured at all times as required by 58A-5.0185(6) FAC.

Findings:

Observations during a tour of the facility on at 5:45AM, found one medication cart in the resident hallway on the left side of the facility was unattended and unlocked. A few minutes later, staff O, a med tech who worked 3PM-7AM, emerged from a resident room and returned to the cart.

On at 5:50AM, Staff O stated he had just gone in the room to assist a resident with medications and confirmed he had forgotten to lock the cart.

Class III

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

Based on observation, staff schedule review and interviews, the facility failed to maintain sufficient staffing during the hours of 11:00PM to 7:00AM to meet the needs of the residents.

Findings:

Observation during a tour of the facility on found the 90 residents in the assisted living facility were spread out in several (6) disconnected resident hallways, plus a locked memory care unit. A large dining room was in the center of the facility. There was one long resident hallway on each side of the dining room. At the far end of one resident hall on the right side of the facility, there was another 2 level section that runs perpendicular to it and has an additional resident hallway "downstairs." On the left side of the facility, off the other long resident hallway, was another area that contained the locked memory care unit and another resident hallway. It is not possible to see activity in adjacent hallways while in any part of another hallway. In addition, there are a few resident apartments that can only be accessed by walking outside into the center courtyard and down several steps.

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Each resident room had a wall mounted pull cord by the bedside for use in case of an emergency. In order to pull the cord, the resident needed to be located near the bed. There was one central station off the dining room where the call bells rang, indicating location. According to the administrator on at 1:10PM, the call bells ring in the central station. The caregiver staff must hear the audible alarm sound and either see the alert light above that resident's door or go to the central station to see which room had called for help. He confirmed it was not possible to hear the alarms or see the alert lights in different hallways other than the one the caregiver was in, and that the resident rooms at the hallway perpendicular to the end of the right sided hallway (1st & basement levels) did not have indicator lights.

Review of the staff schedule for the week of - revealed direct caregiver staff were schedule for 832 hours. The minimum requirement for 90 residents is 539 hours/week.

Review of the record for resident #14 revealed documentation that she was admitted on . Her health assessment documented she had and paranoia and was at risk for . She was in an apartment on the basement level of a resident hallway remote from the center of the facility. There were no call lights outside the room and just the one pull cord in the room by the bedside. Notes indicate in she was experiencing episodes of , reported to staff on that she had out of bed the night before. On , notes document the resident was heard yelling for help during morning rounds, and found on the floor. The resident reported she had at 8pm the night before and no one had come when she called for help. She was unable to reach the pull cord. 911 was called and she was sent to the hospital. Her room was located on the basement level of the far hallway, which was not monitored during the night.

Review of the caregiver schedules for the weeks of - and /19 revealed the facility scheduled 3 unlicensed caregivers in the facility from 11pm-7am for 90 residents spread throughout the facility. One staff is dedicated to the locked memory care unit with 17 residents. The remaining 73 residents are the responsibility of the one med tech and a "floater" staff member who goes and forth between 6 ALF resident hallways and the memory care section.

On at 5:50AM staff O, who was finishing a double shift from 3PM-7AM, expressed concern about the ability to know what is happening in the resident hallways that are remotely located out of sight and hearing distance. He stated they used to have more staff, but not anymore. He was responsible for providing the 6AM medications and said that took a long time, and at the same time he was supposed to help the other residents if they called for help.

On at 6:05AM staff N confirmed her role from 11PM-7AM that night was a "float" staff and she went wherever one of the other 2 staff needed help, or monitored the facility if she wasn't being called.

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She stated it was very difficult to check on everyone and be there to help when one of her 2 coworkers asked for help. She stated the rooms on the basement and 1st level of the end hallway are mostly more independent residents and they do not monitor them through the night.

On at 3:00PM, the nursing director confirmed that they have only been able to schedule 3 staff at night. She confirmed that with 90 residents spread out over the facility, it was not possible to see or hear what was happening in other areas of the facility.

Class III

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

Based on record review and interview, the facility failed to ensure regular and therapeutic menus as served, with substitutions noted before or when the meal is served and kept on file in the facility for 6 months.

Findings:

In an interview on with resident #12 who said whenever the cooks are out or something, the administrator orders about 25-30 pies of pizza, just pizza. The dining room was closed, we ate in our rooms. We were in for about 8 days. There were 32 people with and .

In an interview with the administrator who confirmed the above statement and added that substitutions were not maintained. There was a Noro outbreak on , the 20th, 2019.
Review of the substitution log for the previous 6 months revealed a list of 5 holiday changes to the menu. There were no other changes on the log.

On at 2:30PM, the dietary manager stated she was out for an illness in the past month, but stated she had other cooks who filled in for her and they were never without a cook. She did confirm that she did not understand how to use the substitution log and that the log did not reflect changes made to the menu.

On at 2:45PM, the administrator stated that all the cooks were out at the same time during the norovirus outbreak and he did bring in pizza.

Class III

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0160 - Records - Facility - 58A-5.024(1) FAC

Based on observation, admission and discharge log review, and interview, the facility failed to ensure an accurate and up-to-date log was maintained for 2 of 17 residents.

Findings:

Review of the facility census revealed there were 90 residents in the facility on .

Observation during a tour of the facility on found labeled with the name of resident #16. Review of the census found that was labeled as "open."

Review of the facility's admission and discharge log revealed resident #16 was admitted on , and was not listed as discharged. He was not identified as being out of the facility (i.e. in the hospital or with family) during review with the Director of Nursing. Further review found resident #15, admitted on , was listed as a current resident. She was not listed on the current census.

On at 4:45PM, the administrator stated resident #16 had been sent to the hospital on after repeated . The administrator stated the resident's family had removed his belongings and the resident would not be returning to the facility. Regarding resident #15, the administrator stated the resident had , in .

He confirmed the admission discharge log was not updated for residents #15 and #16.

Class III

N278 - LNS - Records - 58A-5.031(3) FAC; 429.07 (3)(c)2, FS

Based on record review and interview the facility failed to ensure nursing progress notes were maintained for 1 of 14 sampled residents (#16) resident who received Limited Nursing Services (LNS).

Findings:

Resident #6 had a health assessment dated that listed , high , , and .

Healthcare provider order dated indicated care to great left cleanse with normal

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, , , dry, apply and on Monday Wednesday and Friday. The Medication Observation Record (MOR) listed the same.

Healthcare provider order dated care with changes daily. The MOR listed the same and also indicated nurse to change as needed between HHC and indicated changes done on , and .

Healthcare provider order dated indicated LNS for daily care to left hallux (great). changes daily. The MOR listed the above and indicated changes were done on to , and were circled.

The facility LNS notes dated , , and indicated " change to left great ".

The review revealed no evidence to confirm the facility maintained written progress reports each time the service was provided that described the type, amount, duration, scope, and outcome of services that were rendered and the general status of the resident's health.

In an interview on at 2:30 PM with the director of resident care who said there were no other documentation available.

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on Agency background screen website review, staff schedule review and interview, the facility failed to maintain the current employment status of employees within the Agency's Background Screening Clearinghouse for 1 of 17 staff employees (Staff G).

Findings:

Review of the facility staff schedule for revealed staff G, a licensed nurse, was scheduled for work on from 3pm-11pm. She was listed on the schedule for the evening shift 5 days a week.

Review of the facility's employee roster on the Agency's Background Screening Clearinghouse website for the facility revealed Staff G was not listed as an employees of the facility. Further review of the Agency website revealed staff G had an eligitblity date of .

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On at 4:30 PM, the administrator confirmed the findings and said it was probably an oversight.

Unclassified