STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911234	07/03/2019
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
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced Complaint Investigation #2019006073 was conducted from to 3, 2019. Bethesda on Turkey Creek had deficient practice found at the time of the investigation.

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

Based on record reviews, interviews and observations, the facility did not provide a safe environment by not adequately providing supervision during overnight hours for residents.

Findings include:

On at 11:15 AM, the agency requested a copy of the current work schedule from the administrator and resident care manager (RCM). At 12:36 PM, the RCM stated she is concerned about the staffing levels during the night shift. The RCM stated the facility meets the regulation for staff hours but "We only have three staff overnight for 81 residents, which includes Memory Care....This is a problem for resident safety."

Review of duties for the direct caregivers reflected that at the start of each shift, direct caregivers are required to access a walkie-talkie to communicate with one another in case of emergencies. (photo evidence/5).

On at 12:12 PM, during a tour of the facility, it was observed that the facility was divided between Memory Care with 10 rooms, and the Assisted Living Facility (ALF) with 59 rooms. The ALF is divided between the West and East Wings. The space between the two ALF wings is about 30 meters wide and serves as the dining room. If in either wing, one would not know the activity happening in the other wing.

On at 10:30 PM, the front door of the facility was unlocked and open. Upon entering the facility, no one stopped the agency representative, who was able to walk around the facility. On the East wing, staff E saw the agency representative but off without asking any questions. At that time, most of the residents were sleeping but a small group were gathered in the smoking area on the outside patio.

On at 11:02 PM, staff E stated she did not stop the agency representative because she was getting off at 11 PM. Staff E stated she was unaware of how the doors are locked in the evening. She stated the facility does not have enough staff for the overnight shift, especially when someone calls in sick. Staff E stated she does not use the walkie-talkies because they do not work.

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On . . . . . at 11:09 PM, staff F stated he is not sure how the doors are locked at night. He said he has been on the overnight shift for quite some time. Staff F stated he does not use the walkie-talkies because they do not work. Staff F stated they do not have enough staff on the overnight shift because if they had an emergency, they could not get everyone out. Staff F stated he had a number of residents he would need to help get out of bed.

On . . . . . at 11:22 PM, staff H stated the facility does not have enough staff because "There is always a problem in the Memory Care Unit and it leaves the rest of the facility without staff." Staff H stated she is not sure how the front doors are locked at night. Staff H stated she does not use the walkie-talkie.

On . . . . . at 11:33 PM, staff G stated she has worked at the facility for more than 2 years. Staff G stated the overnights are "tough" because sometimes they only schedule two staff for the entire building. Staff G stated she was not aware of how the doors are locked. Staff G stated she does not use the walkie-talkie. Staff G stated she works in the Memory Care Unit. When asked "Who was in the unit while she interviewed?", she stated "No one."

On . . . . . at 8:15 AM, the administrator stated she was unaware of how the building is locked up at night, and has never been in the building during the evening hours. When asked how the agency representative could gain entry and walk around without being stopped, the administrator stated, "That is concerning." The administrator stated she was unaware of staff not using the walkie-talkie.

On . . . . . at 9:49 AM, the RCM stated she is responsible for the direct caregivers, nurses and med technicians. The RCM stated she is concerned about the overnight shift and stated management decides how many staff can be scheduled, and if staff call in sick, she is not allowed to replace them. The RCM stated she is aware that the walkie-talkie only work sometimes.

On . . . . . , a handwritten note was provided which reflected that management has been aware of the broken walkie-talkie and the safety factor. (photo evidence 1).

Review of facility documentation revealed that if the facility had some type of emergency during the overnight hours, the ALF had 25 residents, who required some type of assistance, including four, who would need assistance of 2 people. It revealed that all 11 residents in the Memory Care would need some type of assistance.

Review of the facility payroll for the period of . . . . . to . . . . . revealed the overnight staff levels, which below three staff: - 2 staff, - 2 staff, - 2 staff, - 2 staff, - 2

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staff, - 2 staff, - 2 staff, - 1 staff, - 2 staff, - 2 staff, - 2
staff, - 1 staff, - 2 staff, - 1 staff, - 2 staff, - 1 staff, - 2
staff, - 2 staff, - 2 staff, - 1 staff, - 2 staff, - 2 staff, - 2
staff, - 2 staff, - 2 staff, - 2 staff, - 2 staff, - 2 staff, - 2
staff, - 2 staff (photo evidence 14 and 15).

On at 2:15 PM, the administrator did not know if 25 residents needing assistance and four residents requiring assistance of two people were able to be assisted during an emergency.

Class II

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

Based on record review and interviews, the facility failed to ensure resident safety by providing documentation of First Aid and ( ) training for 3 of 3 staff (F, G & H).

Findings:

On , review of the facility work schedule reflected that staff F, G and H worked alone on the overnight shift, 11 PM to 7 AM.

On at 8:15 AM, the agency requested the administrator provide documentation of staff F, G and H having completed First Aid and training.

On at 2:15 PM, the administrator stated she did not have access to the records.

Class III

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

Based on record review and interviews, the facility failed to ensure 1 of 2 staff were rescreened following a 90-day gap in employment (J).

Findings:

On , staff J's employment file reflected a date of hire of , and a background screening date of . The employment file showed staff J's last position requiring a background screening ended on .

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On , review of the Agency for Health Care Administration's background screening website for the facility reflected a date of hire as and a screening date of . The background screening website showed the last position requiring a background screening ended on , creating a gap of more than 90 days.

On at 2:15 PM, the administrator stated she was unaware of the need to update the background screening regarding a 90-day gap in employment.

Unclassified