

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965313	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/05/2023
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CARLISLE PALM BEACH, THE

**450 EAST OCEAN AVENUE
LANTANA, FL 33462**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced licensure Complaint (#2023004729) survey was conducted on at The Carlisle Palm Beach. The facility had a deficiency identified at the time of the survey.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of _____ or _____ or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such _____ or _____. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making _____ for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide appropriate personal supervision of care and daily observations to ensure the general health, safety and well-being for 3 out of 7 sampled residents (Resident #1, Resident #3 and Resident #4) who were assessed to be at-risk for . . . The findings included: Review of the facility's " . . . management program guideline" issued on . . . revealed the following:	A 025			

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A 025	Continued From page 2 The facility was "committed to minimizing the resident and/or injury and to maximizing each resident's physical, mental and well-being. While preventing all resident is not possible, the community will act in a proactive manner to identify and assess those residents who are at risk for , plan for preventive strategies and facilitate a safe environment". "All must be investigated to he causative reasons/contributing factors. Procedure: All care staff will be responsible in assisting with the implementation of the community's management program to maintain the safety of all residents in the community. The program will include measures which determine the individual needs of each resident by evaluating the risk of and implementation of appropriate interventions to provide necessary supervision and assistive devices as necessary. management program standards: The Health and Wellness Director or designee will evaluate residents for within 24 hours of a resident's move-in, a minimum of every six months, and with a significant condition change as part of the resident's assessment in the EHR (electronic health record) system. If a resident has a , or continues to have , the ISP will be updated with new interventions after each . Immediately following a , the temporary service plan should be initiated by staff. Upon investigation completion, HWD (Health and Wellness Director) or designee will	A 025			

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A 025	Continued From page 3 resolve the temporary Service Plan and update the current ISP with on-going interventions to reduce . . . The goal is to identify interventions to reduce the number of and prevent serious injury from . . . Current interventions and any new interventions added will be discussed with the care staff to ensure full understanding." Review of the facility's " . . . response" Policy and Procedures issued on revealed the following: "Proper response to . . . is part of this process, including staff response and investigation for causative/contributing factors. When a . . . occurs and the Health and Wellness Director or designee is not available for immediate evaluation of the resident, the staff present should follow the procedure below. - "Do not move the resident." - "Obtain vital signs" - "Look for any visible . . . injuries, etc." - "Complete page 1 of post investigation tool" - "Implement temporary service plan for . . ." 1) In an interview conducted with Resident #3 on . . . at 10:10 AM, she stated that she lived in the facility for many years and that she felt that the staff was not approachable. She stated that she was issued a call pendant to call on the staff when she needed assistance, but after so many attempts to call on the staff and receiving delayed or no responses, she gave up using it. She stated	A 025		

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A 025	Continued From page 4 that she was apprehensive to call on the staff to assist her because it seemed that the staff were bothered whenever they came to assist her in her room, especially since she resided on the 6th floor. She stated that she rarely saw staff members on the 6th floor, so it must be difficult for the staff to tend to the residents on the 6th floor since the nursing station, dining room and activities were all on the first floor. She stated that she in while attempting to don her brace on by herself in her bedroom. She stated that she received after this and that she felt that she still needed a helping to perform some of her activities of daily living safely. She stated that instead of bothering the staff she presently carried on by herself using her walker or wheelchair to transfer and ambulate, and she now donned her brace on while sitting so she would minimize her risk for falling again. Review of Resident #3's Medical Examination dated on revealed that she was diagnosed with , ataxia, and history of frequent . Review of this Examination indicated that the resident needed daily oversight as a special precaution and needed total care for ambulation, bathing, , toileting and transferring, and supervision with grooming. Review of the resident's Service Plan dated on , revealed that the resident by tripping coming out of the elevator and the resident needed assistance with applying her brace on. Review of this Service Plan indicated that the resident needed -on assistance from staff with ambulation/mobility and bathing, and staff must monitor resident for	A 025			

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A 025	Continued From page 5 potential. 2) In an interview conducted with Resident #1 on at 10:45 AM, he stated that he did not remember how long he had been in the facility and that he also did not know where his call pendant was located. He stated that his private duty aide usually assisted him with his personal care and the facility staff did not provide . . . -on assistance. In an interview conducted with Resident #1's spouse on . . . at 10:55 AM, she stated that Resident #1 while going to the bathroom on . . . in the early morning, and that no one from the staff responded after the private duty aide attempted to call on the staff several times. She stated that the aide used the telephone to call the staff, pressed on the pendant and pulled on the call . . . on the wall to reach a staff member, but no facility staff member responded immediately. She stated that it was disconcerting that no staff member responded to her husband's . . . that morning and the Emergency Medical Personnel (EMP) responded in short time after calling 911. She stated that she did not know how the EMP got into the building without alerting any facility staff member and the EMP arrived to their room located in the 3rd floor of the facility to assess her husband. She stated that the facility nurse did not assess her husband until several hours later that morning. She stated that Resident #1 received . . . after this . . . but the facility staff did not make themselves available to presently ensure their overall supervision of care. Review of Resident #1's Medical Examination dated on . . . revealed that he was diagnosed with . . . decreased memory and Review of this	A 025			

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A 025	Continued From page 6 Examination indicated that the resident had progressive memory loss and had special precaution. Review of this Medical Examination indicated that he needed assistance with self-administration with daily medications. Further review of the resident's record indicated that there was no recent Service Plan available for review. Review of the facility's investigative report dated on _____, revealed that Resident #1 in his room while toileting, was found on the floor and received an injury with _____/raised area on the _____. Further review of the facility record indicated that there no additional details relating to the interventions implemented to prevent future incidents and there was no risk tool completed for the resident immediately after this _____. In an interview conducted with the Director of Nursing (DON) on _____ at 1:30 PM, she stated that although direct care staff monitor for resident _____, Resident #1 had private duty aides around the clock, so the staff did not provide daily assistance or supervision with the resident's personal care. She stated that on _____, Resident #1 did not call by telephone the nurse on duty to respond to his _____, and this was the reason why no staff member responded that early morning. She stated that the wall call _____ in the resident's room no longer worked, and she believed that all the residents knew about this. She stated that she performed an assessment on Resident #1 when she saw the resident on _____ at approximately 7:30 AM, but she did not document this assessment. She stated that the resident was independent with all of his activities of daily living but she was not aware of the resident's current functional status since the resident was ordered and received _____, _____ after his accident on _____. She	A 025			

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A 025	Continued From page 7 stated at this time that she did not have the assessment for immediate review and to ascertain the resident's current functional status and condition. In an interview conducted with the Administrator on _____ at 1:40 PM, she stated that since she believed that Resident #1 did not press on the call pendant in the early morning of _____, the staff could not respond to his room. She stated that she did not know specifically how the EMP gained access into the facility building, but it was likely that the security guard provided them access. She stated that she received correspondence from Resident #1's family regarding the incident on _____, and she did not respond to the family's inquiries because she deferred this communication to the facility ownership. She also stated that she believed that the facility ownership did not respond to this communication. 3) In an interview conducted with Resident #4 on _____ at 3:05 PM, she stated that the staff was not usually approachable. She stated that she also relied on the pendant to call on the staff whenever she needed assistance with her personal care, but the staff just did not respond to this, especially at night. She stated that she presently needed staff to assist her to find her television remote control and she pressed the pendant at 3:06 PM, and she was sure that no one was going to respond in a timely manner. She stated that she _____ last week in her room and she has _____ many times in the past couple months because she cannot wait prolonged periods of time to go to the bathroom after calling on the staff. She stated that due to her condition, she needed assistance with ambulation, toileting and general mobility.	A 025			

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A 025	Continued From page 8 In an interview conducted with Caregiver Staff A on _____ at 3:15 PM, she stated that she did not receive any pendant call to respond to Resident #4's room at the present time. She stated that if she was alerted from a resident pendant call, she would receive a phone call from the reception to go to the individual resident's room. She stated that since she was presently checking on the 6th floor residents, she would go to check on Resident #4 at this time. Review of Resident #4's Medical Examination dated on _____, revealed that she was diagnosed with _____, gait abnormality, _____ and _____. Review of this Examination indicated that the resident needed supervision with bathing and toileting, and daily assistance with self-administration of medications. Review of the resident's Service Plan dated on _____ revealed that the resident's diagnoses will be monitored and followed by the staff and the resident had a history which required "extensive" and _____-on assistance for ambulation and transfers. Review of the facility's _____ Incident Log revealed that Resident #4 had _____ 4 times on _____ and _____. Review of the facility's investigative report dated on _____, revealed that Resident #4 was found sitting on the floor next to her bed at 3:30 PM. Further review of this report indicated that the resident did not receive an assessment and no _____ risk review tool was completed. Review of the facility's investigative report dated on _____, revealed that Resident #4 was found on the floor in her room at 6:43 AM. Further review of this report indicated that the resident did	A 025			

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A 025	Continued From page 9 not receive an assessment and no risk review tool was completed. On at 4:35 PM, an interview was conducted with the Administrator and DON who were apprised of and acknowledged the findings as per above. Class III	A 025		