STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911749	**03/26/2019**
NAME OF PROVIDER OR SUPPLIER **PRESERVE AT PALM AIRE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **3701 MCNAB ROAD** **POMPANO BEACH, FL 33069**	

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

0000 - Initial Comments

An unannounced standard Relicensure survey was conducted on and at The Preserve At Palm Aire, License #7693. The facility had deficiencies found at the time of the survey.

(An unannounced licensure complaint survey, CCR #2019001420 was conducted in conjunction with the above Relicensure survey. Please see separate report for findings.)

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, record review, and interview, the facility failed to have all residents reassessed to ensure that all residents met the criteria for continued residency at an Assisted Living Facility (ALF) and that the residents Health Assessment Form (AHCA form 1823) was accurate and reflective of their current care needs and services, for 1 of 4 sampled residents (Resident #4).

The findings included:

Observations of Resident #4 on and revealed the resident was laying in bed consecutively both days, not getting up to participate in any activities or to eat any meals provided by the facility. Further observations revealed that the resident had a private care giver assisting with all activities of daily living (ADL's). Additional observations revealed that Resident #4 could not communicate well, and relied on the private care giver to communicate her care needs to others.

During an interview with Resident #4 and the private duty aide (PDA) on it was stated by the PDA that Resident #4 never gets out of the bed and that her and Hospice together take care of the resident. The PDA further stated that she is there four days a week from 7 AM to 9 PM, and that another lady comes in for the other three days a week when she is off. When asked to the resident "do you get out of the bed to go to activities? Resident #4 whispered "no" and shook her left and right. The PDA stated that all of her care is done in the bed. I feed her in the bed, shower her in the bed, we do exercises in the bed. Resident #4 nodded her up and down to indicate yes.

Review of Resident #4's file on revealed a Resident Health Assessment (AHCA form 1823) dated for that stated that the resident has a medical history and diagnosis of , hemiplesia, and and behavioral status stated , , and communication . It stated that the resident is total with all ADL's and that the resident is receiving services from Hospice as of .

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Review of the electronic progress notes provided and written by the Director of Nursing (DON) on revealed that the resident was admitted to the Hospital on and returned on . There is no documentation on the reason the resident was sent to the Hospital or the staff that reported the change in condition of the resident. There was also no documentation of a care plan provided for the resident following up on the care and services needed once returning into the facility or anything from the facility documenting any care provided to the resident at all since of 2018. Review of the Hospice file revealed documentation that Resident #4 is bedbound dated for . There has been no further documentation from the facility on the residents condition since returning from the Hospital on or any documentation of the resident being re-assessed for continued residency after suffering a change in condition.

During an interview with the Director of Nursing (DON) on at 2:37 PM regarding how often Resident #4 gets out of the bed, it was stated that she does have a wheel chair and that the facility staff get her up whenever they can. The DON could not state how often or the last time the facility staff get the resident up out of the bed. The DON also could not provide adequate information about the care and services provided to the resident from Hospice or how often they come and assist Resident #4's PDA. In the event of an emergency, the DON could not provide a plan in place on how the staff will safely evacuate Resident #4. The DON also could not provide any information of how the resident transfers or ambulate after being left in the bed for so long.

During an interview with the Administrator, the DON, and the Memory Care Director on at 3:30 PM the findings of failure to re-assess the resident was discussed and acknowledged, no further information was provided for review.

Class III

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC 429.255(1)(b). FS

Based on record review and interview, the facility failed to ensure Third Pary Services Policy and Procedures were created and used to coordinate care for 1 of 3 sampled residents (Resident#4).

The Findings Included:

On at approximately 1:00PM, a resident record review was conducted for Resident#4 who is

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receiving Hospice Services. At this time, the facility Third Party Services Policy and Procedures were requested. An interview with the Administrator at this time revealed the facility does not have Third Party Policy and Procedures to ensure the coordination of care. Also during the interview the Administrator stated Third Party Service Coordination is done verbally with the providers and the Director of Nursing (DON). The Administrator provided a document labeled documentation requirements, and stated the document was not being used as a facility wide Third Party Services policy and procedure . At this time there is no documentation or policy in place to direct coordination of care for residents receiving Third Party Services.

During an interview with the DON, and Administrator, on at approximately 2:50PM, they acknowledged the findings and provided no additional documentation for review.

Class

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on record review and interview, the facility failed to notify all residents / resident representative in writing of the facility's implementation of the Enviromental Emergency Control Plan (EECP).

The Findings Included:

On at approximately 1:00PM, the facility EECP was requested and reviewed. The review revealed no documentation that the facility notified residents or their representatives of the implementation of the EECP. On at approximately 10:45AM, a interview was conducted with the Administrator who stated they notified them through the process, but no written notification was given to the residents or the residents representative regarding the implementation of the facility EECP.

Durign an interview on at approximately 2:45PM, the findings were acknowledged and no additional documentation was provided for review.

Class