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		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 04/21/201 FORM APPROVE DMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105755	B. WING		04/07/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HEARTL	AND HEALTH CARE	CENTER BOYNTON BEACH		3600 OLD BOYNTON ROAD BOYNTON BEACH, FL 33436	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROLIDERICIENCY)	DBE COMPLETION
	conducted on Health Care Center is not in compliance Requirements for 483.25(I) DRUG RE UNNECESSARY D Each resident's dru unnecessary drugs drug when used in duplicate by without adequate mindications for its us adverse consequer should be reduced combinations of the Based on a compreresident, the facility who have not used given these drugs us a diagnosed and crecord; and residendrugs receive graducture.	Recertification survey was to at Hearland Boynton Beach. The facility with 42 CFP Part 483, ong Term Care Facilities. GIMEN IS FREE FROM RUGS gregimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate is; or in the presence of cess which indicate the dose or discontinued; or any reasons above. Hensive assessment of a must ensure that residents drugs are not miles. Gregion of the condition of the second of the condition of the second	F 329	The statements made on this plan of correction are not and do not constitute an agreement with the alleged deficiencies herein.  To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's alleged compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.  F-329  It is the practice of this facility that each residence the properties of the facility of the facil	ent's drug  ty.  d and the  staff were  non- istering
	drugs. This REQUIREMEN	VT is not met as evidenced		The facility will randomly audit nursing notes first 30 days and randomly for 90 days therea documentation of non-pharmacological inter documented prior to administering of medications. A, audit tool will a ensure that residents are monitored for grad reductions	ofter to ensure ventions is iso be used to

by: Based on record review and interview it was

LABORATORY DIRECTOR'S OR PROVIDENCE REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an assense (') denotes a deficiency which the institution has been excused from correcting providing it is defirmed that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the shortings stated above are discloseable 90 days collowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y2D911

Facility ID: 95019

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BY:\_

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING \_ 105755 B. WING 04/07/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3600 OLD BOYNTON ROAD HEARTLAND HEALTH CARE CENTER BOYNTON BEACH BOYNTON BEACH, FL 33436 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 329 Continued From page 1 F 329 determined the facility failed to ensure the medication regimen was free of unnecessary Results of audits will be brought to the medications for 2 of 5 sampled residents monthly QA&A committee to identify any reviewed for Unnnecessary Medication Use (Resident # 179 and # 88). As evidenced by trends and patterns. failure to implement non pharmacological interventions prior, to administering POC. , 2016 medications for Resident # 179 and failure to ensure gradual dose reduction and behavioral monitoring for Resident # 88. The findings included: 1) Record review conducted on revealed Resident # 179 was admitted to the facility on Minimum Data Set, Admission assessment with documents the reference date resident is severely for daily decision making with a BIMS (Brief Interview Mental Status) score of 5; the resident requires with activities of daily living; has diagnosis of non and and is medications. Care plans initiated for the resident included: "At risk for adverse effects related to use of medication, use of medication and use of medications\* documents interventions as notify physician of decline in activity of daily living.

dated

"Resident is an elopement risk" related to new

cognition with behaviors documents interventions as

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#064 P... 7

PRINTED: 04/21/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING \_\_ 105755 8 WING 04/07/2016 STREET ADDRESS CITY STATE ZIP CODE NAME OF PROVIDER OR SUPPLIER 3600 OLD BOYNTON ROAD HEARTLAND HEALTH CARE CENTER BOYNTON BEACH BOYNTON BEACH, FL 33436 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DESIGNENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DEFICIENCY) F 329 Continued From page 2 F 329 Physician's Order dated documents 0.5 mg, every six hours, as needed for Review of the Medication Administration Record revealed Resident # and 0.5 mg on 179 received and Further review of the clinical record revealed no evidence of the resident's behavior requiring the use of the drug and evidence of non pharmacological interventions implemented prior to administering the Interview with Assistant Director of Nursing

2) Record review revealed Resident #88 was with diagnosis admitted to the facility on without behavioral that includes disturbance, severely , and the resident requires total dependence on mobility Observation of Resident #88 from revealed a non-verbal,

non-interacting resident that sits in a wheel chair unengaged in any kind of activities.

and

Event ID: Y2D911

(ADON) of the Turtle Bay Unit on 9:05 AM revealed after review of the clinical record there is no evidence related to the behavior requiring the use of

confirmed there is no evidence non pharmacological interventions were attempted to reduce the behavior prior to administering the

FORM CMS-2567(02-99) Previous Versions Obsolete

drug.

Facility ID: 95019

If continuation sheet Page 3 of 20

PRINTED: 04/21/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION A. BUILDING 105755 B. WING 04/07/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3600 OLD BOYNTON ROAD HEARTLAND HEALTH CARE CENTER BOYNTON BEACH BOYNTON BEACH, FL 33436 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION m (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 329 Continued From page 3 F 329 Review of physician orders revealed Resident #88 was ordered (a mood stabilizer) on ( an antimedication) on and (an antimedication) on Review of Resident #88 records of pharmacy reconciliation dated i, revealed the pharmacist recommended to re-evaluate for possible discontinuation of recommendation was declined with a rational "this dose maintains a calm for this , (patient) who had been quite agitated and . . . . . " A pharmacy recommendation dated revealed the pharmacist recommended " monitoring . Please provide Documentation of continued need at current dose". The recommendation was declined with a rational " (patient) is stable with current dose which tx (treatment) BPSD (behavioral and .... symptoms of

During an interview and side-by-side chart review with the DON (Director of Nursing) on 3:00 PM, the DON confirmed that there was no documentation of Resident #88's behaviors in the records. The DON could not produce any documentation on why Resident #88 was ordered . The DON confirmed that or Resident #88 was non-verbal and required total assistance. The DON further stated that they chart (document) by exception (only when there is a deviation from the baseline or expected outcome or when a procedure is done) and if nothing is charted, then nothing happened. F 371 483.35(i) FOOD PROCURE,

F371 F 371

It is the practice of this facility that that the facility procures food from sources approved or

SS=F STORE/PREPARE/SERVE - SANITARY

PRINTED: 04/21/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED. A. BUILDING \_ 105755 B. WING 04/07/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3600 OLD BOYNTON ROAD HEARTLAND HEALTH CARE CENTER BOYNTON BEACH BOYNTON BEACH, FL 33436 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CON APLETION DATE REFIX PREFD TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) F 371 Continued From page 4 F 371 The facility must -(1) Procure food from sources approved or considered satisfactory by Federal, State or local considered satisfactory by Federal, State or local authorities; and authorities and that the facility store, prepare, (2) Store, prepare, distribute and serve food distribute and serve food under sanitary under sanitary conditions conditions The dietary staff were in serviced on kitchen sanitation to include clean kitchen surfaces and dishes and utensils. This REQUIREMENT is not met as evidenced by: The wall by the dish machine underneath the Based on observation, interview and record review, the facility failed to ensure kitchen counter/sink was cleaned. The coil to the spray surfaces are clean, and dishes and utensils are nozzle by the dish machine was cleaned. In the cleaned under sanitary conditions. Poor sanitation walk in cooler, the brown sticky substance on can lead to cross contamination and increases the risk of food borne illness. This has the the floor was cleaned and the ice machine vent potential to affect 107 of 109 residents who eat in was also cleaned. The dish machine was the facility. checked by the service vendor on two The findings included: occurrences and found to be in working order. The booster was adjusted to ensure the machine is 100% operational. Estimates for On at 9:05 AM an initial tour of the facility's kitchen was conducted with the Regional replacing the dish machine are in progress. Dietitian and the Food Service Director. The

following observations were made:

- 1) The wall by the dish machine, underneath the counter/sink, was noted to have black built-up residue.
- 2) The coil to the spray nozzle by the dish machine was noted to have black, sticky residue.
- 3) The walk-in cooler was noted to have brown, sticky substance spilled on the floor and wall in

If continuation sheet Page 5 of 20

Kitchen sanitation will be monitored weekly for the first 30 days and randomly thereafter for the

following 90 days. The dish machine will

QA&A to identify any trends or patterns.

, 2016

continue to be monitored daily at each meal.

Results of the audits will be brought to monthly

### PRINTED: 04/21/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING B WING 105755 04/07/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIES

561 496 5924

3600 OLD BOYNTON ROAD BOYNTON BEACH, FL 33436

HEARTLAND HEALTH CARE CENTER BOYNTON BEACH PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES 1D (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 371 Continued From page 5 F 371 the right corner of the unit, by the entrance door. 4) The ice machine vent noted to have dust build up. 5) The dish machine was observed to have a wash reading of up to 164 degrees Fahrenheit but the rinse cycle reached a maximum reading of up to 170 degrees Fahrenheit. The Regional Dietitian told the food service worker who was operating the dish machine (the food service worker was observed on the dirty end of the machine and there were trays with clean dishes on the clean end of the machine that had already gone through the machine) to run it for a while so the machine 's temperature could reach its recommended minimum temperature. After allowing the staff to run the dish washer for at least 10 minutes, the final rinse temperature did not reach beyond 170 degrees Fahrenheit. The Maintenance Director was called in by the Food Service Director. At 9:35 AM, the Maintenance Director arrived and checked the dish machine and stated that the booster was working. He turned on and off the wash/rinse switches and the rinse cycle did not reach 169 degrees Fahrenheit. The Maintenance Director said he would have to contact Hobart to reset the dish machine. At 9:40 AM, the Regional Dietitian instructed the Food Service Director not to have her staff wash the dishes until the machine was fixed. She also instructed the Food Service Director to use paper goods until the machine is fixed and that she would notify the Administrator that they have a problem with the dish machine. The Regional Dietitian stated that she checked the dish

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machine earlier that morning and it was working fine. A review of the facility's dish machine log

revealed: The Minimum temperature for wash Event ID: Y2D911 Facility ID: 95019

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 04/21/2016 FORM APPROVED 91

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-03
THE STATE OF SEPTEMBERS AND ASSESSED.			LE CONSTRUCTION	(X3) DATE SURVE COMPLETED		
		105755	B. WING		04/0	7/2016
		CENTER BOYNTON BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 OLD BOYNTON ROAD BOYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	COMPLETE DATE
F 425 SS=D	180 degrees Fahre The Regional Dietit Director acknowled 483.60(a),(b) PHAF ACCURATE PROC The facility must pri drugs and biologica them under an agre	s Fahrenheit. Rinse cycle = nheit.  sian and the Food Service ged these conditions.  MACCEUTICAL SVC - EDURES, RPH covide routine and emergency is to its residents, or obtain sement described in	F 371	F-425  It is the practice of this facility to routine and emergency drugs a biologicals to its residents.		
	unlicensed personn law permits, but onl supervision of a lice A facility must provi (including procedur acquiring, receiving administering of all the needs of each r The facility must en a licensed pharmac on all aspects of the services in the facili	de pharmaceutical services es that assure the accurate , dispensing, and drugs and biologicals) to meet esident. uploy or obtain the services of ist who provides consultation a provision of pharmacy		Resident #13 still resides in the nurse for this resident received inservice.  Nursing staff were inserviced o adequate pharmaceutical servito irreatments.  Weekly observation audits will completed for patients requirir treatments for the first 30 days audits will be completed there days.	a 1:1  n providing ces relating be  s. Random after for 90	

Based on observation, interview and record review, the facility failed to provide adequate pharmaceutical services for 1 of 1 residents randomly observed (Resident #13). A Licensed Practical Nurse (LPN) left a resident who required medication administration alone during a

monthly QA&A committee to identify any trends and patterns.

POC: Facility ID: 95019

, 2016

If continuation sheet Page 7 of 20

PRINTED: 04/21/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 105755 R WING 04/07/2016 STREET ADDRESS CITY STATE ZIP CODE NAME OF PROVIDER OR SUPPLIER 3600 OLD BOYNTON ROAD HEARTI AND HEALTH CARE CENTER BOYNTON BEACH BOYNTON BEACH, FL 33436 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ED. (X5) COMPLETION DATE (X43 ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 425 Continued From page 7 F 425 breathing treatment. The findings included: at 9:45 AM, the surveyor approached Resident #13's observed the following, Staff A, a LPN, was standing behind the medication cart parked directly in front of the . The door to the resident 's resident's closed. Staff D, a Certified Nurse Aide (CNA) was standing next to the cart conversing with Staff A. Staff A was asked about Resident #13's contracted legs and she described the manner in which they were contracted. The surveyor then asked to observe the resident's legs and was accompanied by Staff A and proceeded to enter Resident #13's . Upon entrance to the , a CNA was observed providing care to Resident #13's , the privacy curtain was pulled close. Resident #13 was sitting in her wheel chair next to her bed receiving a treatment. During the observation, the resident started squirming around and the mask attached to her face became partly dislodged which Staff A corrected. At that time, Staff A was asked if the resident is supposed to be left alone during the breathing treatment. Staff A stated it was okay because she only briefly had to go to her cart to do something, and there was a CNA present.

561 496 5924

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Review of Resident #13's clinical record revealed a quarterly Minimum Data Set assessment dated that documented her

making daily decisions were severely She also required extensive to total assistance

with activities of daily living. Review of the facility's written policy titled, Mist

", dated Event ID: Y2D911

skills for

Facility ID: 95019

If continuation sheet Page 8 of 20

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/21/2016 FORM APPROVED OMB NO. 0938-0391

	105755	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	
CENTERS FOR MEDICARE	& MEDICAID SERVICES	_

(X2) MULTIPLE CONSTRUCTION A BUILDING

(X3) DATE SURVEY COMPLETED 04/07/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 3600 OLD BOYNTON ROAD

HEARTLAND HEALTH CARE CENTER BOYNTON BEACH

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG

ID. PREFIX TAG

F 425

B. WING

BOYNTON BEACH, FL 33436 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

(X5) COMPLETION DATE

F 425 Continued From page 8

disclosed, Switch aerosol unit on and direct patient to inhale mist slowly and deeply; and continue until prescribed medication has been aerosolized from chamber.

During interviews conducted on Staff B, a LPN (Licensed Practical Nurse), at 9:25 AM and Staff C, a (RN) Registered Nurse Supervisor, at 9:30 AM, both stated they stay with the resident for the entire treatment, and that CNAs do not monitor treatments. In an at 2:07 PM, Staff D. interview conducted a CNA, stated CNAs are not allowed to monitor treatments.

This was discussed with the Unit Manager on at 10:16 AM, who stated that the facility's protocol is for the nurse to supervise the resident for the entire treatment. She further stated CNAs are not allowed to monitor treatments. This was discussed with the Assistant Director of Nursing on at 3:10 PM, she stated nurses are to stay with the resident for the entire treatment and that CNAs are not allowed to ... treatments. monitor

F 431 483.60(b), (d), (e) DRUG RECORDS.

SS=D LABELISTORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be

F431 F 431

> It is the practice of this facility to employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of controlled drugs in sufficient detail to enable an accurate

reconciliation; and determines that drug

all controlled drugs is maintained and

periodically reconciled.

records are in order and that an account of

Facility ID: 95019

If continuation sheet Page 9 of 20

Event ID: Y2D911

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/21/2016 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES	200 100 7		C CONSTRUCTION	CX3) DATI	E SURVEY
TATEMENT OF DEFICIENCIES (X1) F ND PLAN OF CORRECTION (C)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		105755	B. WING			04/	07/2016
NAME OF PROVIDER OR SU		ENTER BOYNTON BEACH		3	TREET ADDRESS, CITY, STATE, ZIP CODE 600 OLD BOYNTON ROAD		
REARTLAND REALTH	CARE	ERIER BOTHTON BEHOT		_В	SOYNTON BEACH, FL 33436		
DEELY (EACH DE	FICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC (DENTIFYING INFORMATION)	PREFID TAG	۲	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 431 Continued F	rom pa	ne 9	F4	31			
labeled in ac professional appropriate	ccordan princip access	ce with currently accepted les, and include the ory and cautionary e expiration date when	. 7				endadende de la composition della composition de
facility must locked comp controls, an	In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.				The refrigerator in the Pelican Me replaced and the tempe within acceptable limits.		
permanently controlled d Comprehen Control Act , exce	y affixed rugs list sive Dro of 1976 ept when ug distri red is m	and other drugs subject to the facility uses single unit bution systems in which the inimal and a missing dose can			Other facility refrigerators were a checked to ensure that the temperalso within acceptable limits.  Temperature of the medication will be audited week days and randomly 90 days theresensure compliance with temperate	erature is	
by: Based on c review, it was ensure med	observat as deter dications temper	NT is not met as evidenced don, interview and policy mined the facility failed to swere stored under atures in one of two Pelican unit).	The state of the s		Results of the audit will be brough monthly QA&A to identify and tre patterns.  POC: , 2016	ht to	
The finding	s includ	ed:					
Facility Poli	cy titled	"Refrigerated Medications"			Anne Area		

PRINTED: 04/21/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING\_ B. WING 105755 04/07/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3600 OLD BOYNTON ROAD HEARTLAND HEALTH CARE CENTER BOYNTON BEACH BOYNTON BEACH, FL 33436 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 431 Continued From page 10 F 431 accordance with label directions. Refrigerated medications will be stored at 36-46 degrees Fahrenheit". Medication storage observation conducted on at 9:31 AM in the medication the Pelican Unit while accompanied by the Assistant Director of Nursing (ADON), revealed the temperature of the medication refrigerator was 32 degrees F (Fahrenheit). The ADON confirmed the temperature reading and stated the refrigerator temperature would be adjusted. The medication refrigerator contained the following items: One vial of One vial of One vial of One vial of Lantus One vial of Four Suppositories
One vial of One vial of eye drops One vial of 1 Two vials of · R one gram Two vials of Six vials of

The medication refrigerator contained the FORM CMS-2567(02-99) Previous Versions Obsolete Ever

Turtle Bay Unit for storage.

Pelican Medication

Medication storage observation conducted on the

AM, revealed the temperature in the medication refrigerator was 28 degrees F. The Director of Nursing, who was present during the observation, confirmed the temperature reading of 28 degrees F and stated, all medications will be moved to the

Event ID: Y2D911 Facility ID: 95019

at 9:42

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	S FUR MEDICARE	& MEDICAID SERVICES			
The state of the s		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105755	B. WING		04/07/2016
NAME OF PROVIDER OR SUPPLIER HEARTLAND HEALTH CARE CENTER BOYNTON BEACH				STREET ADDRESS, CITY, STATE, ZIP COD 3600 OLD BOYNTON ROAD BOYNTON BEACH, FL 33436	È
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		IOULD BE COMPLETION
F 431	Continued From pa following items: One vial of Cone vial of One vi	ge 11  positories eye drops  R one gram  for documents in refrigerator ree Fahrenheit. Do not freeze if it has been frozen. for injectable njection should be stored and degrees Fahrenheit.		141 F441  It is the practice of this facilit	ntrol program anitary and
	(a) Contro The facility must es	ol Program stablish an Control		of and	d transmission

Program under which it -

PRINTED: 04/21/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 105755 B. WING 04/07/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3600 OLD BOYNTON ROAD HEARTLAND HEALTH CARE CENTER BOYNTON BEACH BOYNTON BEACH, FL 33436 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX TAG DEFICIENCY) F 441 Continued From page 12 F 441 (1) Investigates, controls, and prevents Resident # 97 and 144 still reside in the in the facility; facility. (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective Resident # 144 no longer requires isolation actions related to precautions. For both resident #97 and 144 as well as other residents, staff was (b) Preventing Spread of (1) When the Control Program control practices reinserviced on determines that a resident needs isolation to including disposing of trash and biomedical , the facility must prevent the spread of the resident. waste appropriately, isolation/contact (2) The facility must prohibit employees with a precautions, cleaning up spills communicable : or skin from direct contact with residents or their food, if appropriately, cross contamination while direct contact will transmit the feeding and proper hand washing (3) The facility must require staff to wash their hands after each direct resident contact for which technique. hand washing is indicated by accepted A weekly audit of control practices professional practice. and hand washing will be conducted for the (c) Linens Personnel must handle, store, process and first 30 days and randomly thereafter for 90 transport linens so as to prevent the spread of control days to ensure that proper techniques are being utilized.

The findings included: FORM CMS-2567(02-99) Previous Versions Obsolete

by:

This REQUIREMENT is not met as evidenced

Based on observations, interviews and record

residents during dining observations; sampled residents (Resident #97 and #144); and 3 of 5 nurses observed during medication administration (Staff B, F and G).

review, the facility failed to maintain control standards as required for 2 of 2 random

Event ID: Y2D911

Facility ID: 95019

trends.

POS:

Results of the audit will be brought to

. 2016

monthly QA&A to identify any patterns or

If continuation sheet Page 13 of 20

### #064 P..../\_\_1 PRINTED: 04/21/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 105755 R WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3600 OLD BOYNTON ROAD HEARTLAND HEALTH CARE CENTER BOYNTON BEACH BOYNTON BEACH, FL 33436 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 441 Continued From page 13 F 441 1. Observation of Resident #97's bathr conducted on / / at 11:25 AM with the facility's Assistant Director of Nursing (ADON) present. A plastic bag containing the resident's urinal and urinal cover was tied to a handrail in the bathi . Two used gauze pads and their wrappers, and a pair of used latex gloves had been inserted into the bag, the gloves were protruding from the top of the bag. The Assistant DON observed the bag and it's contents, and stated this was not acceptable practice. She stated the medical waste should have been placed in a red bag and deposited directly in to the biohazard waste container located in the biohazard . She further stated she would look in to it and try to find out who did it and why. During a follow-up interview conducted at 11:44 AM, the ADON stated she still did not know for sure what happened. This was discussed with the facility's Administrator on / / at 10:02 AM. 2) Resident #144 was admitted / / . with of the bone) of the left toe - ( with (an multi-drug resistant organism). Resident #144's last dose of treatment for the with (an

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with

the initial tour of the facility on

DON, who was also the

remain on contact precautions/isolation until

i. Durina

was on //

were no residents on isolation on the 600 unit. at 11:00 AM an interview with the

Coordinator, stated that all residents admitted are placed on contact

precaution/isolation and are housed in private The DON further stated that the residents

1 there

Control

Facility ID: 95019

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/21/2016

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		(		. 0938-0391
		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		E SURVEY MPLETED	
		105755	B. WING		04/	07/2016
NAME OF PROVIDER OR SUPPLIER HEARTLAND HEALTH CARE CENTER BOYNTON BEACH				STREET ADDRESS, CITY, STATE, ZIP CODE 3600 OLD BOYNTON ROAD BOYNTON BEACH, FL 33436		***************************************
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	COMPLETION DATE
F 441	there was an order by side review of reveal an order to d then stated that the isolation once a resi treatment. The DON #144 did have a DON was not able to documentation or exesident #144 had time of admission.  3. Observation come	to discontinue isolation. Side esident #144's chart did not isscontinue isolation. The DON y sometimes discontinue ident has completed N acknowledged that Resident. Furthermore, the to locate or produce any vidence indicating that been on isolation from the ducted on at the side of	F 441			
	12:30 PM in the 400 assisting a random in The was control tray and spilled milk proceeded to remove protector; wiped the protector and placed neck.  4. Observation of St	Dod revealed a resident in the dining area. observed setting up the food on the table. The re the resident's clothing table clean with the clothing d it back around the resident's			A TOTAL POLYCLE STATE OF THE ST	į

5. During Medication Adminstration observation conducted on at 10:20 AM revealed Staff F performing hand washing prior to the medication adminstration. Staff F washed her hands for six seconds and did not use a paper

random resident with the lunch meal; another resident accross the dining area was attempting to get up from the wheelchair and Staff E got up and assisted the resident back in the chair. Staff E returned to the table and continued feeding the

towel to close the water faucet.

resident without hand hygiene

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If continuation sheet Page 15 of 20

PRINTED: 04/21/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING 105755 B. WING 04/07/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3600 OLD BOYNTON ROAD HEARTLAND HEALTH CARE CENTER BOYNTON BEACH BOYNTON BEACH, FL 33436 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 441 Continued From page 15 F 441 6. Medication adminstration observation conducted on at 10:04 AM revealed Staff B performing hand washing prior to the medication adminstration. Staff B washed her hands for less than five seconds and did not use a paper towel to close the water faucet. 7. Medication adminstration observation conducted on at 9:41 AM revealed Staff G performing hand washing prior to the medication adminstration. Staff F washed her hands for less than five seconds 8. Interview with Staff B on at 2:02 PM revealed the facility policy is to wash hands for at least fifteen seconds and acknowledged she did not use the paper towel to close the water faucet. Interview with Staff F on at 2:11 PM revealed the facility policy is to wash hands for at least fifteen seconds and acknowledged she did not use the paper towel to close the water faucet. Interview with Staff G on at 3:07 PM revealed the staff was made aware of the hand hygiene observation during the medication

enough.

Interview with the Director of Nursing (DON) on ... at 11:55 AM revealed the facility has provided numerous inservices related to hand washing and stated the behavior was not facility practice.

adminstration and stated hand washing is performed for five minutes. The staff was made aware her hand washing lasted less tha five seconds and acknowledged that was not long

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Event ID: Y2D911 Facility ID: 95019

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE	& MEDICAID SERVICES	(	MB NO. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	105755	B. WING	04/07/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY STATE ZIP CODE 3600 OLD BOYNTON ROAD

HEARTLAND HEALTH CARE CENTER BOYNTON BEACH BOYNTON BEACH, FL 33436 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) IPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX FACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)

F 514 | 483.75(I)(1) RES

SS=E RECORDS-COMPLETE/ACCURATE/ACCESSIB

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

Based on interviews and record review, the facility failed to maintain accurate and complete records for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #58) and 12 randomly sampled residents in the 600 unit.

The findings included:

1. During review of medications for Resident #58, the following concern was identified, a physician called for order dated antimedication) 0.5 milligrams at bedtime. The resident's medication administration record (MAR) for and . 2016 documented nursing staff were to observe the resident each shift for side effects of the medication which were listed on the MAR as follows: 0 for no side effects, A for abnormal face, mouth, tongue movement, B for abnormal movement of arms and legs, C for tremors in

F 514

F514

It is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized.

Resident # 58 has a side effects sheet for : medication. The monitoring of orders for resident #88 and the 11 others were signed by the physician.

Nursing staff were reinserviced on monitoring side effects as and documenting of well as timeliness of physician signature for telephone orders.

medications will A random audit of . . . be completed weekly for the first 30 days and randomly thereafter for 90 days to ensure medication monitoring is in place. Orders will also be audited weekly for the first

30 days and randomly thereafter for 90 days to ensure that they are signed and dated timely by the attending physician.

Results of the audits will be brought to monthly QA&A to identify and patterns or trends.

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Event ID: Y2D911

Facility ID: 95019

PRINTED: 04/21/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING 105755 B. WING 04/07/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3600 OLD BOYNTON ROAD HEARTLAND HEALTH CARE CENTER BOYNTON REACH BOYNTON BEACH, FL 33436 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL : COMPLETION DATE PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR USC IDENTIFYING INFORMATION) DEFICIENCY) F 514 Continued From page 17 F 514 extremities, D for abnormal movements of upper body, E for dry mouth, F for difficulty OF , restlessness, disorientation or , and H for Review of the resident's 2016 MAR revealed no documentation of the resident's side effects for the period through at 2:58 PM In an interview conducted the Unit Manager reviewed the 2016 MAR and confirmed nursing staff failed to enter the requirement for monitoring side effects for antimedication. She stated the resident's side effects were being monitored by nursing staff but they falled to document it during 2016. She further stated it was facility protocol to monitor and document side effects on each shift when the resident receives an anti-, medication. 2) Resident #88 was treated for ...... ( an itchy, highly skin caused by an infestation by a mite) on 1/ . During an interview with the DON on at 11:00 the DON stated that all of the residents, a total of 12, in the 600 unit were treated

On at 12:00 PM the DON acknowledged that there was no documentation of treatment for in any of the resident records in the 600 unit. Later, at 12:15 PM the DON then provided the surveyor with 12 MARs (medication administration records) for the residents that were admitted during the time of the infestation. The MARs dated documented (an ) given

The DON further stated that the staff were all

treatment, but all refused.

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offered . , ,

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Facility ID: 95019

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PRINTED: 04/21/2016

		AND HUMAN SERVICES				M APPROVE
		& MEDICAID SERVICES				0. 0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION		TE SURVEY MPLETED	
		105755	B. WING		04	/07/2016
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIF	CODE	
HEARTL	AND HEALTH CARE	CENTER BOYNTON BEACH		3666 OLD BOYNTON ROAD BOYNTON BEACH, FL 33436		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 514	Continued From pa	age 18	F 514	4.		
	to all 12 residents of	-				
		of the MARs were signed by				
	the DON.	o, the mane more eight a p				
	During record revie	w of the 12 resident records				
		which the DON provided the				
		at 12:15 PM, an initiating				
		generate the residents MAR		İ		
	was not located in	the residents charts. The DON				
		ded the surveyor 12 Physician		1		
		Two of the physician telephone				
		ature or date. Ten of the		1		
		e orders were dated				
		y the DON. None of the				
	telephone orders w	ere signed by a physician.				
	During an interview					
		oned by the surveyor as to				-
		its orders and MARs were not				
		arts, the DON stated "I haven't				
	had the time".	cumentation of staff refusing				
		ent, the DON stated that an				
		. The DON then provided a		İ		
		enda Nursing Meeting				
	2016 that included					
		treatment/resident/staff", with				
		dance roster signature.				
	Accompanying the	inservice agenda was a				į
		v Asked Questions (FAQs)				
	document from the					
	and Prevention (CI					
		-PPH				1
	Investigations for	olicy titled, "Outbreak Outbreak", dated				

Facility ID: 95019

561 496 5924

\_ ./\_ // \_\_ .\_ 16:50

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING \_ 105755 B. WING 04/07/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3600 OLD BOYNTON ROAD HEARTLAND HEALTH CARE CENTER BOYNTON BEACH BOYNTON BEACH, FL 33436 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 514 Continued From page 19 F 514 Review of the facility policy titled, "Requirements and Guidelines For Clinical Record Content" dated 2015, under Telephone Orders, Verbal Orders and Secure Messages, it is documented Telephone orders are signed and dated by the attending physician within the period of time defined by state regulations. In the absence of state accreditation time frame requirements, a 30-day time frame is considered "reasonable". It is further documented that the date and time of an order as well as the signature of qualified professional receiving order must be present on each telephone order form.

RECEIVED MAY 0 8 2016

561 496 5924 . /\_//.... 16:50 #064 P. //

	for Health Care Adm	(X1) PROVIDER/SUPPLIER/CLIA	T (200) 1 0 0 70			
		IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G:	(X3) DATE COMP	SURVE
		95019	B. WING		04/0	7/201
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE		17.001
IEARTL	AND HEALTH CARE	CENTER BOYNTE 3600 OLD	BOYNTON	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUILL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	COMP
N 000	INITIAL COMMEN	TS	N 000			
	conducted on Heartland Health C	te-licensure survey was to at are Center Boynton Beach. iclencies at the time of the visit	The Proposition and the same of the same o			
N 095	59A-4.112(6), FAC	Drug Storage	N 095	N095		
	medications requiri stored in a refrigera locked or located w	and non-prescription ng refrigeration must be ator. The refrigerator must be ithin a locked medication le only to licensed staff.		It is the practice of this facility to e obtain the services of a licensed pt establishes a system of records of disposition of controlled drugs in s detail to enable an accurate recon	narmacist wi receipt and ufficient	
	Based on observati review, it was deten ensure medications appropriate tempera			determines that drug records are i that an account of all controlled di maintained and periodically recon The refrigerator in the Pelican Mer replaced and the temperature	rugs is ciled. dication	1
	The findings include	ed:		acceptable limits.		
	dated de medications will be accordance with lab	"Refrigerated Medications" ocuments "Refrigerated stored and used in el directions. Refrigerated stored at 36-46 degrees		Other facility refrigerators were all ensure that the temperature is als acceptable limits.  Temperature of the medication refrigerators will be audited week	o within ly for 30 day	
1	/2016 at 9:31 / the Pelican Unit whi Assistant Director of the temperature of the was 32 degrees F (F confirmed the temperature of the temperature	observation conducted on AM in the medication le accompanied by the function function (Nursing (ADON), revealed he medication refrigerator Fahrenheit). The ADON rerature reading and stated the ture would be adjusted.		and randomly 90 days thereafter tompliance with temperature.  Results of the audit will be brough QA&A to identify and trends or pa POC: ', 2016	nt to monthl	У

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	r Health Care Adm	inistration			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			1		1
		95019	B. WING		04/07/0040
		85019	1-,,,,,,		04/07/2016
NAME OF PR	OVIDER OR SUPPLIER	STREET A	DORESS, CITY,	STATE, ZIP CODE	
		3600 OL	BOYNTON	ROAD	
HEARTLA	ND HEALTH CARE (		N BEACH, F		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	
			i	DEFICIENCY)	
			†		
N 095 C	Continued From page	ge 1	N 095		
F	Saead on obeensti	on, interview and policy			
		mined the facility failed to	1		
		were stored under	1		İ
		atures in one of two	i		
			1		· ·
ı	nedication (i	Pelican unit).	1		
					1
7	tha Badhana lastinda		1		
	he findings include	eu:			
	*	MD after a second at a second as a second	1		
		"Refrigerated Medications"			: 1
		ocuments "Refrigerated	1		
	nedications will be		[		
		el directions. Refrigerated	1		
		stored at 36-46 degrees	1		i
F	ahrenheit".				
					į
, N		observation conducted on			1
		AM in the medication			:
ti	ne Pelican Unit whi	le accompanied by the			
Δ.	ssistant Director of	Nursing (ADON), revealed			
ti	ne temperature of t	he medication refrigerator			
v	vas 32 degrees F (I	ahrenheit). The ADON			
c	onfirmed the temp	erature reading and stated the			
re	efrigerator tempera	ture would be adjusted.			
		•			:
1	he medication refri	gerator contained the			}
	ollowing items:	-			1
	one vial of	I i	1		1
C	ne vial of		1		
	one vial of		1		
	one vial of Lantus				
	one vial of		-		1
	ne vial of				1
	our Su	ppositories			
	ne vial of	eve drops			
	one vial of (	)			1
	wo vials of	R . ,			1
	wo vials of				
,	77G 71BIG 01	, one grain	1		

AHCA Form 3020-0001 STATE FORM

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if continuation sheet 2 of 7

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STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		95019	B. WING		04/07/2016
AME OF	PROVIDER OR SUPPLIER	STREET A	DORESS, CITY, ST	FATE ZIP CODE	1 040/12010
(FADT)		2600.01	D BOYNTON R		
1EAR IL	AND HEALTH CARE		ON BEACH, FL		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE COMPLETE DATE
N 095	Continued From p	age 2	N 095		
#	Six vials of				
		observation conducted on the			
	Pelican Medication				
	refrigerator was 28	emperature in the medication degrees F. The Director of			i
	Nursing, who was	present during the observation.			
	confirmed the temp	perature reading of 28 degrees	1 1		
	F and stated, all m	edications will be moved to the			
	Turtle Bay Unit for	storage.			
	The medication ref	rigerator contained the			
	following items:	rigidator contained the			ĺ
	One vial of	J			
	One vial of	·			1
	One vial of One vial of Lantus	J			3
	One vial of				
	One vial of				
		ppositories			
	One vial of	eye drops			
	One vial of ( Two vials of	, R ;			
	Two vials of	one gram			
	Six vials of	, one grann	1 1		
	The product insert t				
	keep all unopened hetween 36-46 dea	in refrigerator ree Fahrenheit. Do not freeze	l		
	and do not use	if it has been frozen.			
		-			
	The product insert f documents is				
	transported 36-46 d	njection should be stored and legrees Fahrenheit.			
	The product insert f				
		frigerated at 36-46 degrees			
- 1	Fahrenheit.				
	20-0001				i

Agency	for Health Care Adm	inistration			PRINTED: 04/21/201 FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED	
		95019	B. WING		04/07/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY	STATE, ZIP CODE	
HEARTL	AND HEALTH CARE		BOYNTON		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECT	ON (X5)
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
N 095	Continued From pa	ge 3	N 095		
			1		1
	Class III			N101	
N 101	400.141(1)(j), FS; 5	9A-4.118(2), FAC Resident	N 101	It is the practice of this facility to ma	intain
33-D	Medical Records			clinical records on each resident in a	ccordance
	400.141(1)(i) FS			with accepted professional standard	is and
	Keep full records of	resident admissions and		practices that are complete, accurate	ely
	discharges; medical	and general health status,		documented, readily accessible and	İ
		cords, personal and social		systematically organized.	
		and address of next of kin or may have responsibility for the			
		nt; and individual resident		Resident # 58 has a side effects she	et for
	care plans, including	, but not limited to,		monitoring of medicat	ion. The
		service frequency and		orders for resident #88 and the 11 of	thers were
	open to agency insp	e goals. The records must be ection. The licensee shall		signed by the physician.	
		ords on each resident in epted professional standards		Nursing staff were reinserviced on I	monitoring
	and practices, which				ide effects as
		ted, readily accessible, and		well as timeliness of physician signa	
	systematically organ	ized.			ture to
	FOA 4 440(0) FAO			telephone orders.	
	59A-4.118(2) FAC	must contain sufficient		A random audit of medica	tions will be
		identify the resident, his or		completed weekly for the first 30 days	
	her diagnosis and tre			thereafter for 90 days to ensure	
				medication monitoring is in place. Ord	ers will also be
		is not met as evidenced by: and record review, the		audited weekly for the first 30 days and	
		tain accurate and complete		thereafter for 90 days to ensure that th	ey are signed
	records for 1 of 5 sai	mpled residents reviewed for tions (Resident #58) and 12		and dated timely by the attending phys	ician.
		esidents in the 600 unit.		Results of the audits will be brought to	monthly
	The findings included	5		QA&A to identify and patterns or trend	
	-	nedications for Resident #58.		POC: , 2016	

AHCA Form 3020-0001 STATE FORM

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If continuation sheet 4 of 7

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PRINTED: 04/21/2016

Agency for Health Care Adm	inistration			FORM APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	95019	B. WING		04/07/2016	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HEARTLAND HEALTH CARE (		BOYNTON N BEACH, FI			
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE COMPLETE	
order dated anti- medic bedtime. The reside record (MAR) for documented nursing resident each shift for medication which we follows: 0 for no side mouth, tongue move movement of arms: extremities, D for ab body, E for dry mout resident extra for the reside revealed no docume effects for the period in an interview condithe Unit Manager reand confirmed nursi requirement for mon anti- resident's side effect nursing staff but they 2016. She fur	n was identified, a physician called for(an atlon) 0.5 milligrams at antis medication administration and2016 . It staff were to observe the or side effects of the relisted on the MAR as reflects, A for abnormal face, ment, B for abnormal and legs, C for tremors in normal movements of upper h, F for difficulty or smooth and the staff was a considerable of the staff was a considerable of the staff was a considerable of the staff was a considerable of the staff was facility and document side effects on esident receives and	N 101			
12, in the 600 unit w The DON further stat	skin caused by ite) on During DON on at 11:00 , all of the residents, a total of				

AHCA Form 3020-0001 STATE FORM

Y2D911

If continuation sheet 5 of 7

						D: 04/21/2016 1 APPROVED	
Agency for Health Care Administration  STATEMENT OF DEFICIENCES  AND PLAN OF CORRECTION  (X1) PROVIDENCIAL DENTIFICATION NUMBER  95019		,,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		95019	B. WING	B. WING		04/07/2016	
NAME OF PRO	VIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, S	TATE, ZIP CODE	····	1 0 0 0 1 1 2 0 1 0	
HEARTLAN	D HEALTH CARE		OLD BOYNTON F NTON BEACH, FL				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
N 101 C	ontinued From pa	ge 5	N 101			:	
tre re Di (m re thi do an	at there was no do partment for cords in the 600 u DN then provided nedication adminis sidents that were e infestation. The comented all 12 residents or d . All o e DON.	in any of the resident nit. Later, at 12:15 PM the the surveyor with 12 MAF tration records) for the admitted during the time o MARs dated (an ) give the 7-3 shift on fit he MARs were signed b	ds f			a (pri compan) sample (a bas) companyone sample	
in M/ ph wa su tel ord ph an	the 600 unit, for wars on a ysician order to gus not located in the bequently provide phone orders. There had no signary sician telephone d were signed by	v of the 12 resident recorn hinch the DON provided the tt 12:15 PM, an initiating enerate the residents MAR be residents Charts. The Die dd the surveyor 12 Physicia wo of the physician teleph ture or date. Ten of the orders were dated the DON. None of the re signed by a physician.	e CON ian one				
12 wh in ha WI ins	y the the resident the residents char d the time" nen asked for doc treatme ervice was done. cument titled Ager 16 that included to	ned by the surveyor as to s orders and MARs were r ts, the DON stated "I have umentation of staff refusin nt, the DON stated that an The DON then provided a da Nursing Meeting	n't 9				

no employee attendance roster signature.
Accompanying the inservice agenda was a
"Frequently Asked Questions (FAQs) AHCA Form 3020-0001 STATE FORM

/outbreak/treatment/resident/staff", with

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If continuation sheet 6 of 7

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PRINTED: 04/21/2016 FORM APPROVED

Agency for Health Care Adi	ministration			FURM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION 5:	(X3) DATE SURVEY COMPLETED
	95019	B. WING		04/07/2016
NAME OF PROVIDER OR SUPPLIES	STREET AD	DRESS, CITY.	STATE, ZIP CODE	
HEARTLAND HEALTH CARE		BOYNTON N BEACH, F		
PREFIX (EACH DEFICIENCE	ATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
N 101 Continued From p	age 6	N 101	1	
document from the and Prevention (C	Centers for Control			777
Investigations for , it is docum employees, wheth defined area, whice building, are treate Review of the faci and Guidelines For dated 2015, under Telephone orders at tending physiciar defined by state re state accreditation 30-day time frame further documents order as well as the	h may be a unit or the entire d with a scabicidal medication. Ifly policy titled, "Requirements or Clinical Record Content", Telephone Orders, Verbal Messages, It is documented are signed and dated by the within the period of time guiations. In the absence of time frame requirements, a is considered "reasonable". It is that the date and time of an esignature of qualified in order must be present on			
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Class III				
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HCA Form 3020-0001 TATE FORM	6	ж ү	'2D911	If continuation sheet 7 of 7



RICK SCOTT GOVERNOR

ELIZABETH DUDEK SECRETARY

. , 2016

Administrator Heartland Health Care Center Boynton Beach 3600 Old Boynton Road Boynton Beach, FL 33436

## Dear Administrator:

On 3, 2016 - 3, 2016, a Recertification and Licensure Survey was conducted in your facility by representatives from this office.

The purpose of this visit was to determine if your facility was in compliance with requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found not in substantial compliance with the participation requirements.

Enclosed are the provider's copies of Form CMS-2567 (Statement of Deficiencies and Plan of Correction) and State (3020) Form. These forms reference the deficiencies that were identified during the visit.

A Plan of Correction (POC) for the deficiencies must be submitted to this Field Office 10 days after your facility receives the faxed Form CMS-2567. Failure to submit an acceptable POC within ten (10) days after receipt of the faxed statement of deficiencies may result in the imposition of remedies. You will be notified by telephone or fax if your POC is found to be acceptable. If your POC is found to be unacceptable, you will be informed in writing. The correction date indicated by the facility shall be after the date of survey exit. Deficiencies shall be corrected no later than 2016.

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
- How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken:
- What measures will be put into place or what systematic changes you will make to
  ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

Deiray Beach Field Office 5150 Linton Boulevard, Suite 500 Deiray Beach, FL 33484 Phone:(561) 381-5840; Fax:(561) 496-5924 AHCA.MyFlorida.com



Facebook.com/ACHAFlorida Youtube.com/AHCAFlorida Twitter.com/AHCA\_FL SlideShare.net/AHCAFlorida Heartland Health Care Center Boynton Beach ..., 2016 Page 2

## Recommended Remedies:

Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other sanction is warranted, we will provide you with a separate formal notification of that determination.

Remedies will be recommended for imposition by CMS if your facility has failed to achieve substantial compliance by the revisit. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended. A change in the seriousness of the noncompliance found may result in a change in the remedy recommended. When this occurs, you will be advised of any change in remedy.

- · Civil Money Penalty, in an amount and duration to be determined by CMS.
- A mandatory denial of payment for new admissions will be imposed substantial compliance is not achieved by that time.
- Termination of Medicare Agreement. We are recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on 2016 if substantial compliance is not achieved by that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, the CMS Regional Office or State Medicaid Agency will impose the other remedies indicated above, or a revised remedy, if appropriate.

## Informal Dispute Resolution:

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

> Attention: IDR Coordinator Agency for Health Care Administration 2727 Mahan Drive, Mail Stop 9-A Tallahassee, Florida 32308 FAX (850) 414-6946 or

Phone number: (850) 412-4301 IDRCoordinator@ahca.myflorida.com

The IDR request must be sent during the same 10 days you have for submitting a Plan of Correction for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <a href="http://ahca.myflorida.com/Publications/Forms.shtml">http://ahca.myflorida.com/Publications/Forms.shtml</a> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged

Heartland Health Care Center Boynton Beach

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and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representatives. If you have questions, please contact this office at (561) 381-5840.

Sincerely.

Arlene Mayo - Davis Field Office Manager

AMD/jw Enclosure

R6WB