STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964664	**06/05/2017**
NAME OF PROVIDER OR SUPPLIER **ARDEN COURTS OF DELRAY BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **16150 JOG RD.** **DELRAY BEACH, FL 33446**	

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

0000 - Initial Comments

An unannounced Limited Nursing Services survey was conducted on at Arden Courts of Delray Beach, License #9424 . The facility had deficiencies at the time of the visit.

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

Based on observation, interview and record review, the facility failed to determine the appropriateness of admission and continued appropriateness of residence of 1 (Resident #1) of 2 residents reviewed.

The finding include:

Record review on for Resident #1 found she was admitted to the facility on with a diagnosis of and . Review of the facility progress nursing notes document that Resident #1 was assessed on admission and documented to have "light redness to area, red soft skin peel area to the left heel. Hard scab to left outer side of left foot". Resident #1 was seen by a Physician Podiatry Physician on in which documentation states "the was debrided due to presence of and or non-viable tissue".

During an interview on at 10:30 am with the Resident Care Director, she confirmed that Resident #1 was admitted to the facility with a scab to the left foot. She confirms that the podiatrist removed the scab and a local area Home Health Agency is currently caring for the which has yet to heel completely. When asked for documentation of the care such as staging, measurements, or documentation that the is improving, none were produced. The Resident Care Director stated she would have to call the home health agency and have them send over notes. She confirmed at that time she had no other documentation in the facility about the or documentation to show the was improving.

Review of the documentation sent from the local area Home Health Agency on found documentation of a Home Health visit by a registered nurse on . The forms dated documented Resident #1 skin status as left ankle with measurements 0.5 cm X 0.5 cm x 0.1 cm. Left heel measured 2.0 X 1.5 x 0.1. Left foot lateral 0.5 x 0.5 x 0.1 (not staged). Right heel redness measured 2.5 x 2.5 x 0. The wounds were again measured on with the description form documenting only the left ankle (0.4 x 0.4 x 0.1), and left lateral foot which was then identified as a (0.4 x 0.4 x 0.1) remained. The wounds were again measured on documenting an increase in size of the remaining wounds both measured 0.5 x 0.5 x 0.1.

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During a follow-up interview with the Resident Care Director on at 12:00 PM, she confirmed that it had been over 30 days and Resident #1 still required treatment for wounds to the left foot and there was no documentation that the wounds have improved. She confirms that the facility failed to keep information on file and coordinate with the third party service in order to determine if Resident #1 remained appropriate for residency and that the facility had no plans in place nor have spoken to the resident's representative to discharge the resident or transfer to a higher level of care. She says that Resident #1 had an upcoming appointment with the physician and she will discuss it with him and the Administrator.

Class III

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC

Based on interview and record review, the facility failed to coordinate with third party services regarding a resident's condition and the services being provided, for 1 of 2 (Resident #1) resident's reviewed.

The findings include:

Record review on for Resident #1 found she was admitted to the facility on with a diagnosis of , , , , and . Review of the facility progress nursing notes document that Resident #1 was assessed on admission to the and documented to have "light redness to area, red soft skin peel area to the left heel. Hard scab to left outer side of left foot". Resident #1 was seen by a Physician Podiatry Physician on in which documentation states "the was debrided due to presence of and or non-viable tissue".

During an interview on at 10:30 am with the Resident Care Director, she confirmed that Resident #1 was admitted to the facility with a scab to the left foot. She confirms that a local area Home Health Agency is currently caring for the which has yet to heal completely. When asked for documentation of the care such as staging, measurements, or documentation that the is improving, none were produced. The Resident Care Director stated she would have to call the home health agency and have them send over notes. She confirmed at that time she had no other documentation in the facility about the type of , staging, measurements, or any documentation to show the was improving.

Review of the documentation sent from the local area Home Health Agency on found

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During a follow-up interview with the Resident Care Director on at 12:00 PM, she confirmed that it had been over 30 days and Resident #1 still required treatment for wounds to the left foot. She also confirmed there was no documentation in the facility prior to surveyor request regarding the wounds and care progress. She confirms that the facility failed to keep information on file and coordinate with the third party service in order to determine if Resident #1 remained appropriate for residency in an ALF.

Class III

0086 - Training - ADRD - 58A-5.0191(9) FAC

Based on record review and interview, the facility failed to ensure that 1 out of 2 sampled staff (Staff C) had documentation of 4 hours of training on 's and Related Level II (ADRD).

The findings include:

Review of the facility staffing schedule found that Staff C is scheduled to work as direct care staff several times in the month of 2017. A record review conducted on revealed Staff C's hire date as . Further review revealed Staff C's file had no documentation indicating completion of 4 hours of training in ADRD Level II within 9 months of employment. .

In an interview conducted on at 10:00 AM, the Administrative Services Coordinator, she confirmed that Staff C remains employed as a direct care staff and acknowledged Staff C did not complete the training but is schedule to complete it next week.

Class III