STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105666	A. BUILDING _____ B. WING _____	C 01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANIER TERRACE	12740 LANIER ROAD JACKSONVILLE, FL 32226

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Unannounced complaint surveys, CCR #2017014480, CCR #2017014493, CCR #2017015291 and CCR #2018000036, were conducted on - at Lanier Terrace. The facility is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. .	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/ , etc.) CFR(s): 483.10(g)(14)(i)-( )(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following 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.

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F 580	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. ( ) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to consult with the resident's physician regarding a change in health status requiring an alteration in treatment for one (Resident #4) out of 7 sampled residents. The findings include: 1. A record review for Resident #4 revealed a date of admission of and a discharge on . Diagnoses included unstable , , difficulty in walking, and muscle . A review of Resident #4's laboratory results from	F 580	Without admitting or conceding either the existence or scope or severity of the deficiencies Lanier Terrace submits this plan of correction in order to be in compliance with the Regulations. Resident #4 discharged on , 2018 no corrective action can be taken at this time. Other Residents having the potential to be affected: All Residents residing in the facility which have a change in condition have the potential to be affected by this deficient	

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F 580	Continued From page 2 @ 6:00 AM, revealed the following abnormal results: is amber & cloudy, 1+ , Leukocyte Esterase 3+, Protein 1+, Red Count ( ) 5-10 (ref range 0-4) White count ( ) 51-100 (reference range 0-4) clumps many, trace (reference range negative), , cells (reference range 0-4) many present. A review of nurses' notes for Resident #4 dated at 11:23 PM read,"Resident has been very this evening. Resident has been in bed for writer's shift. Vital signs , 90 pulse, 16, and temperature 98.5. Resident would mumble something at times but did not move much. She would not take her oral medications this evening. Resident usually wakes up and states that she is or gets upset that someone uncovered her legs. This evening the resident did not budge or make noise. Resident did not eat her dinner. Staff will continue to monitor resident." There was no documentation the physician was notified. A nurse's note dated @ 3:22 PM read, "Resident is alert with . Power of attorney (POA) informed that resident refused 9:00 AM medications; resident preferred to sleep. Resident left the facility with the daughter at 12:00 PM. Will continue plan of care. There was no documentation the physician was notified of the resident's refusal of medications. A nurse's note dated at 11:51 PM read, "Resident arrived at facility at 8:30 PM. Resident appeared . Resident's is , pulse 87, temperature 102.7, 20. Resident was given 650 mg (milligrams) and Dr. notified and gave order	F 580	practice. Current Resident charts are being monitored to ensure proper notification of change in condition is being communicated. Measurements or systemic changes: Licensed Nurses received in-service training on , 2018 by the ADON on Proper Documentation of Change in Condition. The North Wing Unit Manager and South Wing Unit Manager will review documentation daily to ensure notification of change in condition is communicated to Physician/ARNP; this will be done by Each Unit Manager running the Facility Activity Report which lists all Progress Notes within last 24 hours. The Review of the documentation will be completed by each Unit Manager; Each Unit Manager will be responsible to address as necessary. The ADON will provide continuing education and disciplinary actions if needed. The Unit managers will then submit the Completed Daily Facility Activity Reports to the ADON daily. Monitoring to ensure the deficient practice will not recur: North Wing Unit Manager and South Wing Unit Manager will review daily documentation for change in condition and the notification thereof. This will be added to the daily responsibilities of the Unit Managers. ADON will conduct weekly random audits for six weeks, then bi-monthly for 3 months, and then monthly for 3 months across both units for change in condition documentation and to ensure notification was communicated to the appropriate	

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F 580	Continued From page 3 for resident to be sent to the hospital." A review of hospital records for Resident #4's emergency revealed that the resident was admitted for acute , , and chronic pancytopenia. The History and Physical dated read, "Resident #4 typically is a wanderer and over the past 2 weeks she has gradually become less and less interactive and finally her family wanted her to come to the Emergency department when she was no longer able to feed or dress herself." A review of hospital test results revealed the following abnormal results: Protein 30+, positive, Leukocytes large amount, - 12 (reference range 0-5), 78 (reference range 0-5) clumps 2 (reference range - rare), 3+ (A) (reference range - none) /Creatnine 25 (reference range 6-22). A nurse's noted dated @ 1:52 PM read, "Resident was lying in bed yesterday. On a normal day she would be walking around the facility, however that did not occur. Vital signs , 97% 18, 98. She did eat lunch but was slow with her movement." There was no documentation to indicate that the doctor was made aware of the resident's change in status. A nurse's note dated at 1:56 PM read, "Resident was given all medications and still remains to have the slow movement. The physician assistant was made aware of the behavior. Resident did not eat her food today as well."	F 580	party. All audits (daily as well as the random ADON audits) will be submitted to DON or designee weekly. The DON will report the findings of the audits to QAPI and QA monthly meeting for three months and then quarterly for three quarters.	

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F 580	Continued From page 4	F 580		

A nurse's note dated at 3:51 PM revealed that due to family's request, resident was sent to the hospital due to a change in mental status.

A review of the physician's progress notes revealed no documentation of the resident becoming or any physician's visits due to the change in the resident's status.

A review of a Physician Assistant note dated (after resident hospitalization) read, "Patient reportedly developed a along with inability to feed or dress herself, and her daughter asked to transfer her to acute care hospital for assessment. The patient was apparently treated with Intra- ( ) and then converted to for 5 days."

A review of facility care plan for Resident #4 revealed the resident was at risk for complications related to incontinence, such as pain, ( ), and . Interventions included but were not limited too: Give meds (medications) as ordered, toilet as needed, encourage fluids, obtain labs as ordered, and report signs of (acute , urgency, frequency, and spasms, etc.)."

During an interview with Employee B, Physician Assistant (PA), on at 12:50 PM, he stated that a resident was not started on for a positive culture unless the culture came back positive and they were having symptoms. If the resident was having symptoms , another test would be obtained. The PA confirmed the facility staff did not notify him that Resident #4 was and had a change in

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F 580	Continued From page 5 her mental status. He stated, "I don't recall, but if they had told me that, I would have treated her." The PA confirmed the resident was admitted to the hospital with acute , on .	F 580		
F 675 SS=D	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for two (Residents #4 and #5) out of 7 sampled residents as evidenced by a failure to assess for change in status and follow up appropriately. Failure to assess and identify changes in physical, mental or , , status can result in undesirable/detrimental outcomes for the resident (s) involved. The findings include: 1. A record review for Resident #4 revealed a date of admission of and a discharge on	F 675	Without admitting or conceding either the existence or scope or severity of the deficiencies, Lanier Terrace submits this plan of correction in order to be in compliance with the Regulations. Resident #4 discharged on , , 2018 no corrective action can be taken at this time. Resident #5 discharged on , 2018 no corrective action can be taken at this time. Other Residents having the potential to be affected: All Residents residing in the facility which have a change in condition and require proper follow up have the potential to be	

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F 675	Continued From page 6 . Diagnoses included unstable , , difficulty in walking, and muscle . A review of Resident #4's laboratory results from @ 6:00 AM, revealed the following abnormal results: is amber & cloudy, 1+ , Leukocyte Esterase 3+, Protein 1+, Red Count ( ) 5-10 (ref range 0-4) White count ( ) 51-100 (reference range 0-4) clumps many, trace (reference range negative), , cells (reference range 0-4) many present. A review of nurses' notes for Resident #4 dated at 11:23 PM read,"Resident has been very this evening. Resident has been in bed for writer's shift. Vital signs , 90 pulse, 16, and temperature 98.5. Resident would mumble something at times but did not move much. She would not take her oral medications this evening. Resident usually wakes up and states that she is or gets upset that someone uncovered her legs. This evening the resident did not budge or make noise. Resident did not eat her dinner. Staff will continue to monitor resident." There was no documentation the physician was notified. A nurse's note dated @ 3:22 PM read, "Resident is alert with . Power of attorney (POA) informed that resident refused 9:00 AM medications; resident preferred to sleep. Resident left the facility with the daughter at 12:00 PM. Will continue plan of care. There was no documentation the physician was notified of the resident's refusal of medications. A nurse's note dated at 11:51 PM	F 675	affected by this deficient practice. Current Resident charts are being monitored to ensure proper notification of change in condition is being communicated and that follow up is appropriate for the situation. Measurements or systemic changes: Licensed Nurses received in-service training on , 2018 by the ADON on Proper Documentation of Change in Condition. The North Wing Unit Manager and South Wing Unit Manager will review documentation daily to ensure notification of change in condition is communicated to Physician/ARNP; this will be done by Each Unit Manager running the Facility Activity Report which lists all Progress Notes within last 24 hours. The Review of the documentation will be completed by each Unit Manager; Each Unit Manager will be responsible to address as necessary. The ADON will provide continuing education and disciplinary actions if needed. The Unit managers will then submit the Completed Daily Facility Activity Reports to the ADON daily. The Risk Manager received in-service training from the Corporate Nurse Consultant on how to properly maintain the Accident/Incident Report Log. Monitoring to ensure the deficient practice will not recur: North Wing Unit Manager and South Wing Unit Manager will review daily documentation for change in condition and the notification thereof. This will be added to the daily responsibilities of the Unit Managers. ADON will conduct weekly random audits for six weeks, then bi-monthly for 3	

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F 675	Continued From page 7	F 675		

read, "Resident arrived at facility at 8:30 PM. Resident appeared . Resident's is , pulse 87, temperature 102.7, 20. Resident was given 650 mg (milligrams) and Dr. notified and gave order for resident to be sent to the hospital."

A review of hospital records for Resident #4's emergency revealed that the resident was admitted for acute , , , and chronic pancytopenia. The History and Physical dated read, "Resident #4 typically is a wanderer and over the past 2 weeks she has gradually become less and less interactive and finally her family wanted her to come to the Emergency department when she was no longer able to feed or dress herself."

A review of hospital test results revealed the following abnormal results: Protein 30+, positive, Leukocytes large amount, - 12 (reference range 0-5), 78 (reference range 0-5) clumps 2 (reference range - rare), 3+ (A) (reference range - none) /Creatnine 25 (reference range 6-22).

A nurse's noted dated @ 1:52 PM read, "Resident was lying in bed yesterday. On a normal day she would be walking around the facility, however that did not occur. Vital signs , 97% 18, 98. She did eat lunch but was slow with her movement." There was no documentation to indicate that the doctor was made aware of the resident's change in status.

A nurse's note dated at 1:56 PM read, "Resident was given all medications and still

months, and then monthly for 3 months across both units for change in condition documentation and to ensure notification was communicated to the appropriate party. Corporate Nurse Consultant or designee will conduct monthly audit of the Accident/Incident Report Log to ensure all Accident/Incidents are listed on the Report Log. This audit will be done by running a Monthly Summary of Events Report. All audits will be submitted to DON or designee weekly. The DON will report the findings of the audits to QAPI and QA monthly meeting for three months and then quarterly for three quarters.

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F 675	Continued From page 8	F 675		

remains to have the slow movement. The physician assistant was made aware of the behavior. Resident did not eat her food today as well."

A nurse's note dated at 3:51 PM revealed that due to family's request, resident was sent to the hospital due to a change in mental status.

A review of the physician's progress notes revealed no documentation of the resident becoming or any physician's visits due to the change in the resident's status.

A review of a Physician Assistant note dated (after resident hospitalization) read, "Patient reportedly developed a along with inability to feed or dress herself, and her daughter asked to transfer her to acute care hospital for assessment. The patient was apparently treated with Intra- (,) and then converted to , for 5 days."

A review of facility care plan for Resident #4 revealed the resident was at risk for complications related to incontinence, such as pain, , ( ), and . Interventions included but were not limited too: Give meds (medications) as ordered, toilet as needed, encourage fluids, obtain labs as ordered, and report signs of (acute , urgency, frequency, and spasms, etc.)."

During an interview with Employee B, Physician Assistant (PA), on at 12:50 PM, he stated that a resident was not started on for a positive culture unless the

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F 675	Continued From page 9	F 675		

culture came back positive and they were having symptoms. If the resident was having symptoms , another test would be obtained. The PA confirmed the facility staff did not notify him that Resident #4 was and had a change in her mental status. He stated, "I don't recall, but if they had told me that, I would have treated her." The PA confirmed the resident was admitted to the hospital with acute on .

2. A record review for Resident #5 revealed a date of admission of and a readmission date of . Diagnoses included but were not limited to late effect leg , and , .

A nurses progress note for Resident #5 dated read, "CNA (certified nursing assistant) notified this writer around 1:30 PM of change in the resident leg after she gave her a shower. Resident left leg is flaccid, slightly around the knee joint, and is not warm to touch. During assessment the resident has no complaints of pain at this time. Medical Doctor (MD) notified and orders for a stat X-RAY of the left leg received."

A review of the portable X-ray report for Resident #5 dated @ 3:02 PM read, "There is an acute , of the femur seen. Old healed injuries of the , and are noted. Mild to moderate (,) noted. "

A review of nurses progress note dated at 8:00 PM (late entry @ 12:32 AM) reads, "Resident received a stat X-ray of the left knee at 5:00 PM. Results are there is

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F 675	Continued From page 10 acute [illegible] of the [illegible] femur seen. [illegible] is seen. Mild to moderate [illegible] noted there is no focal bone [illegible]. Writer assessed resident left knee, now noted slightly bigger than right knee." A review of the facility Accident/Incident report log revealed no listing of the femur [illegible] for Resident #5 sustained on [illegible] after receiving a shower from facility staff. An interview with the Director of Nursing (DON) on [illegible] at confirmed the facility did not list the [illegible] for Resident #5 on the facility Accident/Incident log. She stated, "This was a spontaneous/[illegible] and there is nothing we could have done about it." The DON confirmed the facility never conducted an investigation and was not able to provide information that Resident #5's record which revealed her [illegible] was spontaneous/[illegible]. She confirmed the X-ray report for Resident #5 read she had [illegible] and due to that the [illegible] was considered spontaneous or [illegible]. (Photographic evidence obtained) A review of the facility's Policy and Procedure for Accident/Incident investigating and reporting dated [illegible] read, "Facility staff is to immediately report all accidents or incidents to the Nurse Supervisor/Charge Nurse or direct supervisor. Types of incidents/accidents include but may not be limited to: Unusual activity or occurrence." (Photographic evidence obtained) .	F 675		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2)	F 919		

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F 919	Continued From page 11 §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to ensure residents where equipped to call for staff assistance through a communication system which relayed a call directly to a centralized staff work area for 14 residents (Residents #19, #7, the North Wing nursing station, and residents in 401, 701 A & B, 702 C, 703 A & B, 705 B, 707 A, 710, 407 B, 201 A, and 102 B) with the potential to affect all 116 residents currently living in the facility due to the audible alarm component of the call light system not being able to be heard by staff. The findings include: An observation was conducted on at 8:34 AM of the dietary staff delivering the breakfast tray for Resident #19. The resident was not able to set up her breakfast tray and this surveyor obtained permission from the resident to activate her call light to request assistance. This surveyor activated the call light for Resident #19 on at 8:35 AM. This surveyor then left resident observed multiple staff members walking by the answering the call light or offering the resident assistance.	F 919	Without admitting or conceding either the existence or scope or severity of the deficiencies, Lanier Terrace submits this plan of correction in order to be in compliance with the Regulations. Residents #19, #7 North Wing and Residents in , 701a-b, 702c, 703a-b, 705b, 707a, 710, 407b, 201a and 102b - manual call bells were placed in all in the facility and 15-minute resident checks were implemented for all residents on until call system was repaired. Other Residents having the potential to be affected: All Residents residing in the facility have the potential to be affected by the deficient practice. On , a 100% audit was performed on the call light system. All resident call lights throughout the facility were checked for proper function by authorized service provider. The audit revealed all lights were properly functioning at the time of the audit with no corrective action needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105666	A. BUILDING _____ B. WING _____	C 01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANIER TERRACE	12740 LANIER ROAD JACKSONVILLE, FL 32226

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F 919	Continued From page 12 This surveyor then walked to the nurses station for the North Wing and no audible alarm could be heard for the call light for Resident #19. An interview with Employee D, Registered Nurse (RN), on at 8:36 AM, confirmed no audible alarm could be heard at the nurses' station for the call light that was activated for Resident #19. An interview was conducted on at 8:37 AM with Employee E, Certified Nursing Assistant (CNA), and Employee E confirmed the audible alarm for the call light system was not working in the North Wing and she would put a call in to maintenance. An interview with the Director of Nursing (DON) on at 8:39 AM confirmed the audible alarm for the call light system for the North Wing was not alarming at the desk. This surveyor then activated the call light for on at 8:40 AM. A light could be visualized on the ceiling outside the resident's no audible alarm could be heard. An interview with the DON on at 8:41 AM confirmed that the facility nursing staff were not able to hear the audible alarm system if they were not sitting at the nurses' station, and must check the hallways to observe for activated call lights (lights on the ceiling) to know if a resident's call light had been activated. The call light in A & B was activated on at 8:45 AM, and both the audible and visual call lights were found not functioning.	F 919	Measurements or systemic changes: All staff will be in-serviced by ADON on the proper procedure to notify management of any call light failure. Authorized Service Provider added additional audible speakers in seven locations throughout the facility and changed the tone of the ringer to a louder audible sound. Checking the call lights for functionality and audible sound will be added to the routine maintenance task list utilizing the Call Light form. Monitoring to ensure the deficient practice will not recur: Maintenance Director or designee will randomly audit call lights for functionality and audible once a week times four weeks, then semi-monthly, and then return to systematic monthly audit. The findings will be reported to the Administrator. The Administrator or designee will report the findings of audits at monthly QAPI and QA meetings for three months and quarterly for 3 quarters.	

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F 919	Continued From page 13	F 919		

An interview on . . . . at 8:47 AM with Employee F, Licensed Practical Nurse (LPN), confirmed the call lights for . . . . A & B bed were not working.

The call light for 703 B bed was activated on . . . . . at 8:48 AM and was observed not functioning. An interview with Employee F was conducted at that time and confirmed the call light was not working.

The call light for 703 A bed was activated on . . . . . at 8:49 AM and was not functioning. An interview with Employee G, certified nursing assistant (CNA), and the Administrator at that time confirmed the call light was not working.

The call light for B bed was activated on . . . . . at 8:52 AM and was found not working. An interview with Employee H, CNA on . . . . . at 8:53 AM confirmed the call light was not working.

An interview was conducted for Resident #7 on . . . . . at 9:05 AM confirmed her call light has not been working for a long period of time. She stated, "We have told them so many times that it doesn't work. It will work for awhile, but then it doesn't work again." The resident confirmed she had to sit in her own feces and due to the long wait time to get assistance.

An interview with Employee E, Registered Nurse (RN), on at 9:24 AM, confirmed the audible alarm for the call light system for the North Unit was very faint and difficult to hear, and was not able to turn the volume up.

The call light for . . . . A was activated on

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F 919	Continued From page 14	F 919		

at 9:45 AM. The light on the hallway ceiling outside the found to be lit, but no audible alarm could not be heard.

An interview with Employee C, LPN, on at 9:48 AM confirmed the call light for was activated but Employee C was not able to hear the audible alarm at the South Wing nurses' station.

An audit was conducted of the facility call light system by this surveyor which revealed the following call lights were not functioning:

on at 11: 15 AM A bed was found not working.
on at 11: 17 AM A bed was found not working.
on at 11:18 AM both A & B bed and the lights were not working.
on .2018 at 11:20 AM C bed was not working.
on at 11: 28 AM call light was found not working.
on at 12:15 PM B bed was found not working.
on at 12:07 PM B bed was found not working.

An interview with Employee K, Maintenance Director, on at 11:32 AM confirmed he had been the maintenance director for 3 months, and during that time had not performed routine audits on the call light system.

An interview with Employee I, CNA, on at 11:55 AM confirmed she could only see the call light which is lit on the ceiling and never paid

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F 919	Continued From page 15	F 919		

attention to the audible alarm.

An interview with Employee F, LPN, on at 12:00 PM confirmed that if you were not standing by the nurses' station you couldn't hear the call light sounding. When asked whether Employee F knew that the call light for wasn't working, Employee F replied, "I thought it was fixed. Maintenance was told months ago. We have been having issues with the call lights. Sometimes the bed touches the cord and it affects the call light coming on."

An interview with Employee H, CNA, on at 12:00 PM stated, "There are wire shortages in the call light in some of the residents' ." The employee confirmed she knew that a resident was asking for assistance by checking the lights on the ceiling, but said she couldn't hear the audible alarm.

An observation was conducted of Employee F, LPN, on at 12:08 PM, which confirmed she could not hear the audible alarm that was activated at the North Wing nurses' station that she was standing adjacent to.

An interview with Employee J, CNA, on at 12:09 PM confirmed she did not know the facility had an audible alarm to the call light system, and she had to walk into the hallway to see if a call light was activated.

An interview was conducted with the family of Resident #20 on at 11:50 AM, and the family member confirmed that his mother had to wait a long time (as long as 2 hours) for her call light to be answered and receive assistance. He stated that she waited so long that she had soiled

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F 919	Continued From page 16 herself waiting to be assisted. "I don't know if it's because it doesn't work, but it takes a long time for her to get help." .	F 919		

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	41616	A. BUILDING: _____ B. WING _____	C 01/11/2018

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N 000	INITIAL COMMENTS Unannounced complaint surveys, CCR #2017014480, CCR #2017014493, CCR #2017015291 and CCR #2018000036, were conducted on - . Lanier Terrace (Lic #12880962) had deficiencies identified at the time of the visit.	N 000		
N 110 SS=D	400.141(1)(h) FS; 59A-4.122(1) FAC Physical Environment - Safe, Clean, Homelike 400.141(1)(h) FS Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner. 59A-4.122(1) FAC The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible This Statute or Rule is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to maintain the facility premises and equipment, and conduct its operations in a safe manner by failing to ensure residents where equipped to call for staff assistance through a communication system which relayed a call directly to a centralized staff work area for 14 residents (Residents #19, #7, the North Wing nursing station, and residents in . . . 401, 701 A & B, 702 C, 703 A & B, 705 B, 707 A, 710, 407 B, 201 A, and 102 B) with the potential to affect all 116 residents currently living in the facility due to the audible alarm component of the call light system not being able to be heard by staff.	N 110	Without admitting or conceding either the existence or scope or severity of the deficiencies, Lanier Terrace submits this plan of correction in order to be in compliance with the Regulations. Residents #19, #7 North Wing and Residents in . . . . . , 701a-b, 702c, 703a-b, 705b, 707a, 710, 407b, 201a and 102b - manual call bells were placed in all in the facility and 15- minute resident checks were implemented for all residents on until call system was repaired.	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

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N 110	Continued From page 1 The findings include: An observation was conducted on at 8:34 AM of the dietary staff delivering the breakfast tray for Resident #19. The resident was not able to set up her breakfast tray and this surveyor obtained permission from the resident to activate her call light to request assistance. This surveyor activated the call light for Resident #19 on at 8:35 AM. This surveyor then left resident observed multiple staff members walking by the answering the call light or offering the resident assistance. This surveyor then walked to the nurses station for the North Wing and no audible alarm could be heard for the call light for Resident #19. An interview with Employee D, Registered Nurse (RN), on at 8:36 AM, confirmed no audible alarm could be heard at the nurses' station for the call light that was activated for Resident #19. An interview was conducted on at 8:37 AM with Employee E, Certified Nursing Assistant (CNA), and Employee E confirmed the audible alarm for the call light system was not working in the North Wing and she would put a call in to maintenance. An interview with the Director of Nursing (DON) on at 8:39 AM confirmed the audible alarm for the call light system for the North Wing was not alarming at the desk. This surveyor then activated the call light for on at 8:40 AM. A light could be	N 110	Other Residents having the potential to be affected: All Residents residing in the facility have the potential to be affected by the deficient practice. On , a 100% audit was performed on the call light system. All resident call lights throughout the facility were checked for proper function by authorized service provider. The audit revealed all lights were properly functioning at the time of the audit with no corrective action needed. Measurements or systemic changes: All staff will be in-serviced by ADON on the proper procedure to notify management of any call light failure. Authorized Service Provider added additional audible speakers in seven locations throughout the facility and changed the tone of the ringer to a louder audible sound. Checking the call lights for functionality and audible sound will be added to the routine maintenance task list utilizing the Call Light form. Monitoring to ensure the deficient practice will not recur: Maintenance Director or designee will randomly audit call lights for functionality and audible once a week times four weeks, then semi-monthly, and then return to systematic monthly audit. The findings will be reported to the Administrator. The Administrator or designee will report the findings of audits at monthly QAPI and QA meetings for three months and quarterly for 3 quarters.	

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N 110	Continued From page 2 visualized on the ceiling outside the resident's no audible alarm could be heard. An interview with the DON on at 8:41 AM confirmed that the facility nursing staff were not able to hear the audible alarm system if they were not sitting at the nurses' station, and must check the hallways to observe for activated call lights (lights on the ceiling) to know if a resident's call light had been activated. The call light in A & B was activated on at 8:45 AM, and both the audible and visual call lights were found not functioning. An interview on at 8:47 AM with Employee F, Licensed Practical Nurse (LPN), confirmed the call lights for A & B bed were not working. The call light for 703 B bed was activated on at 8:48 AM and was observed not functioning. An interview with Employee F was conducted at that time and confirmed the call light was not working. The call light for 703 A bed was activated on at 8:49 AM and was not functioning. An interview with Employee G, certified nursing assistant (CNA), and the Administrator at that time confirmed the call light was not working. The call light for B bed was activated on at 8:52 AM and was found not working. An interview with Employee H, CNA on at 8:53 AM confirmed the call light was not working. An interview was conducted for Resident #7 on at 9:05 AM confirmed her call light has	N 110		

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N 110	Continued From page 3 not been working for a long period of time. She stated, "We have told them so many times that it doesn't work. It will work for awhile, but then it doesn't work again." The resident confirmed she had to sit in her own feces and . due to the long wait time to get assistance. An interview with Employee E, Registered Nurse (RN), on . . . . . at 9:24 AM, confirmed the audible alarm for the call light system for the North Unit was very faint and difficult to hear, and was not able to turn the volume up. The call light for A was activated on . . . . . at 9:45 AM. The light on the hallway ceiling outside the found to be lit, but no audible alarm could not be heard. An interview with Employee C, LPN, on . . . . . at 9:48 AM confirmed the call light for was activated but Employee C was not able to hear the audible alarm at the South Wing nurses' station. An audit was conducted of the facility call light system by this surveyor which revealed the following call lights were not functioning: on . . . . . at 11: 15 AM . . . . A bed was found not working. on . . . . . at 11; 17 AM . . . . A bed was found not working. on . . . . . at 11:18 AM . . . . both A & B bed and the lights were not working. on .2018 at 11:20 AM C bed was not working. on at 11: 28 AM call light was found not working. on at 12:15 PM B bed was	N 110		

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N 110	Continued From page 4 found not working. on at 12:07 PM B bed was found not working. An interview with Employee K, Maintenance Director, on at 11:32 AM confirmed he had been the maintenance director for 3 months, and during that time had not performed routine audits on the call light system. An interview with Employee I, CNA, on at 11:55 AM confirmed she could only see the call light which is lit on the ceiling and never paid attention to the audible alarm. An interview with Employee F, LPN, on at 12:00 PM confirmed that if you were not standing by the nurses' station you couldn't hear the call light sounding. When asked whether Employee F knew that the call light for wasn't working, Employee F replied, "I thought it was fixed. Maintenance was told months ago. We have been having issues with the call lights. Sometimes the bed touches the cord and it affects the call light coming on." An interview with Employee H, CNA, on at 12:00 PM stated, "There are wire shortages in the call light in some of the residents' ." The employee confirmed she knew that a resident was asking for assistance by checking the lights on the ceiling, but said she couldn't hear the audible alarm. An observation was conducted of Employee F, LPN, on at 12:08 PM, which confirmed she could not hear the audible alarm that was activated at the North Wing nurses' station that she was standing adjacent to.	N 110		

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N 110	Continued From page 5 An interview with Employee J, CNA, on . . . . . at 12:09 PM confirmed she did not know the facility had an audible alarm to the call light system, and she had to walk into the hallway to see if a call light was activated. An interview was conducted with the family of Resident #20 on at 11:50 AM, and the family member confirmed that his mother had to wait a long time (as long as 2 hours) for her call light to be answered and receive assistance. He stated that she waited so long that she had soiled herself waiting to be assisted. "I don't know if it's because it doesn't work, but it takes a long time for her to get help." Class III	N 110		
N 201 SS=D	400.022(1)(l), FS Right to Adequate and Appropriate Health Care The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide adequate and appropriate health care consistent with the resident care plan, and with established standards within the community for two (Residents #4 and #5) out of 7 sampled residents as evidenced by a failure to assess for	N 201	Without admitting or conceding either the existence or scope or severity of the deficiencies, Lanier Terrace submits this plan of correction in order to be in compliance with the Regulations. Resident #4 discharged on	

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N 201	Continued From page 6 change in status and follow up appropriately. Failure to assess and identify changes in physical, mental or [illegible] status can result in undesirable/detrimental outcomes for the resident (s) involved. The findings include: 1. A record review for Resident #4 revealed a date of admission of [illegible] and a discharge on [illegible]. Diagnoses included unstable [illegible], [illegible], difficulty in walking, and muscle [illegible]. A review of Resident #4's laboratory results from [illegible] @ 6:00 AM, revealed the following abnormal results: [illegible] is amber & cloudy, 1+ [illegible], Leukocyte Esterase 3+, Protein 1+, Red [illegible] Count ([illegible]) 5-10 (ref range 0-4) White [illegible] count ([illegible]) 51-100 (reference range 0-4) [illegible] clumps many, [illegible] trace (reference range negative), [illegible], [illegible] cells (reference range 0-4) [illegible] many present. A review of nurses' notes for Resident #4 dated [illegible] at 11:23 PM read,"Resident has been very [illegible] this evening. Resident has been in bed for writer's shift. Vital signs [illegible], 90 pulse, [illegible] 16, and temperature 98.5. Resident would mumble something at times but did not move much. She would not take her oral medications this evening. Resident usually wakes up and states that she is [illegible] or gets upset that someone uncovered her legs. This evening the resident did not budge or make noise. Resident did not eat her dinner. Staff will continue to monitor resident." There was no documentation the physician was notified. A nurse's note dated [illegible] @ 3:22 PM	N 201	2018 no corrective action can be taken at this time. Resident #5 discharged on [illegible], 2018 no corrective action can be taken at this time. Other Residents having the potential to be affected: All Residents residing in the facility which have a change in condition and require proper follow up have the potential to be affected by this deficient practice. Current Resident charts are being monitored to ensure proper notification of change in condition is being communicated and that follow up is appropriate for the situation. Measurements or systemic changes: Licensed Nurses received in-service training on [illegible], 2018 by the ADON on Proper Documentation of Change in Condition. The North Wing Unit Manager and South Wing Unit Manager will review documentation daily to ensure notification of change in condition is communicated to Physician/ARNP; this will be done by Each Unit Manager running the Facility Activity Report which lists all Progress Notes within last 24 hours. The Review of the documentation will be completed by each Unit Manager; Each Unit Manager will be responsible to address as necessary. The ADON will provide continuing education and disciplinary actions if needed. The Unit managers will then submit the Completed Daily Facility Activity Reports to the ADON daily. The Risk Manager received in-service training from the Corporate Nurse Consultant on how to properly maintain the Accident/Incident Report Log.	

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	41616	A. BUILDING: _____ B. WING _____	C 01/11/2018

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N 201	Continued From page 7 read, "Resident is alert with . . . . . . Power of attorney (POA) informed that resident refused 9:00 AM medications; resident preferred to sleep. Resident left the facility with the daughter at 12:00 PM. Will continue plan of care. There was no documentation the physician was notified of the resident's refusal of medications. A nurse's note dated . . . . . at 11:51 PM read, "Resident arrived at facility at 8:30 PM. Resident appeared . . . . . Resident's . . . . , is , pulse 87, temperature 102.7, ... 20. Resident was given . . . 650 mg (milligrams) and Dr. notified and gave order for resident to be sent to the hospital." A review of hospital records for Resident #4's emergency revealed that the resident was admitted for acute . . . . . , , , , and chronic pancytopenia. The History and Physical dated read, "Resident #4 typically is a wanderer and over the past 2 weeks she has gradually become less and less interactive and finally her family wanted her to come to the Emergency department when she was no longer able to feed or dress herself." A review of hospital test results revealed the following abnormal results: Protein 30+, ... positive, Leukocytes large amount, - 12 (reference range 0-5), ... 78 (reference range 0-5) . . . . . clumps 2 (reference range - rare), . . 3+ (A) (reference range - none) . . . /Creatnine 25 (reference range 6-22). A nurse's noted dated @ 1:52 PM read, "Resident was lying in bed yesterday. On a normal day she would be walking around the	N 201	Monitoring to ensure the deficient practice will not recur: North Wing Unit Manager and South Wing Unit Manager will review daily documentation for change in condition and the notification thereof. This will be added to the daily responsibilities of the Unit Managers. ADON will conduct weekly random audits for six weeks, then bi-monthly for 3 months, and then monthly for 3 months across both units for change in condition documentation and to ensure notification was communicated to the appropriate party. Corporate Nurse Consultant or designee will conduct monthly audit of the Accident/Incident Report Log to ensure all Accident/Incidents are listed on the Report Log. This audit will be done by running a Monthly Summary of Events Report. All audits will be submitted to DON or designee weekly. The DON will report the findings of the audits to QAPI and QA monthly meeting for three months and then quarterly for three quarters.	

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N 201	Continued From page 8 facility, however that did not occur. Vital signs , 97% 18, 98. She did eat lunch but was slow with her movement." There was no documentation to indicate that the doctor was made aware of the resident's change in status. A nurse's note dated at 1:56 PM read, "Resident was given all medications and still remains to have the slow movement. The physician assistant was made aware of the behavior. Resident did not eat her food today as well." A nurse's note dated at 3:51 PM revealed that due to family's request, resident was sent to the hospital due to a change in mental status. A review of the physician's progress notes revealed no documentation of the resident becoming or any physician's visits due to the change in the resident's status. A review of a Physician Assistant note dated (after resident hospitalization) read, "Patient reportedly developed a along with inability to feed or dress herself, and her daughter asked to transfer her to acute care hospital for assessment. The patient was apparently treated with Intra- (,) and then converted to , for 5 days." A review of facility care plan for Resident #4 revealed the resident was at risk for complications related to incontinence, such as pain, , ( ), and . Interventions included but were not limited too: Give meds (medications) as ordered, toilet as needed, encourage fluids, obtain labs as ordered, and report signs of (acute	N 201		

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N 201	Continued From page 9 , urgency, frequency, and spasms, etc.)." During an interview with Employee B, Physician Assistant (PA), on at 12:50 PM, he stated that a resident was not started on for a positive culture unless the culture came back positive and they were having symptoms. If the resident was having symptoms , another test would be obtained. The PA confirmed the facility staff did not notify him that Resident #4 was and had a change in her mental status. He stated, "I don't recall, but if they had told me that, I would have treated her." The PA confirmed the resident was admitted to the hospital with acute on . 2. A record review for Resident #5 revealed a date of admission of and a readmission date of . Diagnoses included but were not limited to late effect leg , , and , . A nurses progress note for Resident #5 dated read, "CNA (certified nursing assistant) notified this writer around 1:30 PM of change in the resident leg after she gave her a shower. Resident left leg is flaccid, slightly around the knee joint, and is not warm to touch. During assessment the resident has no complaints of pain at this time. Medical Doctor (MD) notified and orders for a stat X-RAY of the left leg received." A review of the portable X-ray report for Resident #5 dated @ 3:02 PM read, "There is an acute of the femur seen. Old healed injuries of the , and are noted. Mild to moderate (,) noted.	N 201		

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N 201	Continued From page 10 " A review of nurses progress note dated at 8:00 PM (late entry @ 12:32 AM) reads, "Resident received a stat X-ray of the left knee at 5:00 PM. Results are there is acute of the femur seen. is seen. Mild to moderate noted there is no focal bone . Writer assessed resident left knee, now noted slightly bigger than right knee." A review of the facility Accident/Incident report log revealed no listing of the femur for Resident #5 sustained on after receiving a shower from facility staff. An interview with the Director of Nursing (DON) on at confirmed the facility did not list the for Resident #5 on the facility Accident/Incident log. She stated, "This was a spontaneous/, and there is nothing we could have done about it." The DON confirmed the facility never conducted an investigation and was not able to provide information that Resident #5's record which revealed her was spontaneous/, . She confirmed the X-ray report for Resident #5 read she had and due to that the was considered spontaneous or , (Photographic evidence obtained) A review of the facility's Policy and Procedure for Accident/Incident investigating and reporting dated read, "Facility staff is to immediately report all accidents or incidents to the Nurse Supervisor/Charge Nurse or direct supervisor. Types of incidents/accidents include but may not be limited to: Unusual activity or occurrence."	N 201		

Agency for Health Care Administration

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N 201	Continued From page 11 (Photographic evidence obtained) . Class III	N 201		