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	105521	A. BUILDING ______ B. WING ______	01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT BOCA RATON, INC.	1130 NW 15TH STREET BOCA RATON, FL 33486

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F 000	INITIAL COMMENTS An unannounced Recertification survey was conducted on to at Avante at Boca Raton, Inc. The facility is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and ( ) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: /2019

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 625	Continued From page 1 by: Based on interviews and record review the facility failed to provide the bed hold policy notice for hospital discharge for 1 of 4 sampled residents (Residents #4). The findings included: Review of the record revealed that Resident #4 was admitted to facility on ; readmitted to facility on ; and then discharged to the hospital on . His diagnoses included acute , , , failure and . Review of the Minimum Data Set (MDS) dated showed that Resident #4 is with a ( ) score of 03 indicating that he has severe . Section A of the MDS showed that he had an unplanned discharge to an acute hospital. Section Q of the MDS showed that Resident #4 participates in his assessments. In an interview conducted on at 1:35 PM with Staff B, Unit Manager, he reported that when residents are discharged to the hospital the facility provides them with the bed hold policy and the nursing home transfer and discharge notice. When asked if Resident #4 received the bed hold policy, Staff B reported that he was not in the facility when the Resident was discharged, and he is not sure if he received the correct paperwork. Surveyor asked if he had the bed hold/nursing home discharge notice for Resident #4 and he replied no. Staff B stated that it is the responsibility of the social worker to provide the bed hold policy and the nursing home discharge notice. In an interview conducted on at 1:48 PM	F 625	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole purpose of compliance with State and Federal Regulations. F625 (D) - Notice of Bed Hold Policy and Return 1) What corrective action will be accomplished for those residents found to have been affected by this practice? " Resident # 4 no longer resides in this Facility. 2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken. " On , Executive Director/designee completed a comprehensive audit of discharges to the hospital in the last 30 days. For residents who remained in the hospital, the facility sent a Bed Hold Notice via certified mail to the resident and/or responsible party ensuring they were aware of the bed hold policy. 3) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? " By , the Director of Nursing or designee completed Re-education with the facility Licensed nursing staff on the components of F625 with emphasis on ensuring the facility completes a Bed Hold Notification Form at time of discharge or	

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F 625	Continued From page 2 with the social worker, she reported that when residents are discharged to the hospital it is the responsibility of nursing to provide all the paperwork. She further stated that if the residents are discharged to the community then she provides all the discharge documentation and notices. In an interview conducted on . . . . at 2:20 PM with the Director of Nursing, she stated that if residents are discharged to the hospital it is the responsibility of nursing to provide the bed hold policy. She further stated that an in-service was provided to nursing regarding discharge policies and notices.	F 625	as soon as possible after discharge to the resident and/or their responsible party. " Newly hired Licensed Nursing Staff will be educated to the components of F625 with specifications to the above-mentioned areas. 4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place? " Director of Nursing/designee to randomly audit 5 resident records of residents transferred to the hospital to ensure that a bed hold was provided to the resident/responsible party weekly x 4 weeks and then monthly x 2 months. " Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and . . . . needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		

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F 656	Continued From page 3 or maintain the resident's highest practicable physical, mental, and , ¸ well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. ( )In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and observations the facility failed to implement a comprehensive person-centered care plan to meet a resident's mental and , ¸ needs for 1 of 14 residents reviewed for care plans (Resident #60). The findings included:	F 656	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole purpose of compliance with State and Federal Regulations.	

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F 656	Continued From page 4 In an interview conducted on at 1:00 PM, Resident #60 stated that he has not been out of bed since he was admitted. He further stated that he would like to participate in activities but is not able to read the Activity Schedule that is posted on the wall across from his bed. He further reported that he was never seen by the Activity Director while in the facility. During this interview, Resident #60's wife reported that he has not been out of bed since he was admitted. She further stated that they are waiting on a wheelchair to be able to get out of bed, and that the administrator told them that a new shipment of wheelchairs are expected to come in. Record review revealed that Resident #60 was admitted on with diagnoses of: , following a infraction effecting the left non-dominant side. He was admitted to hospice on . Review of the care plan dated revealed that Resident #60 is at risk for self-care performance and balance. He has limited range of motion and he uses side of rails to assist him with bed mobility. Closer review of the care plan showed no plan for activities created by the activity director. In an interview conducted on at 1:17 PM with Staff B, Unit Manager, he reported that Resident #60 has no order that restricts him from getting out of bed. He further reported that there is no care plan done for activities. Staff B stated that he has not seen Resident #60 out of bed in the past few weeks. In an interview conducted with the Rehab Director	F 656	F656 (D) - Develop/Implement Comprehensive Care Plan 1) What corrective action will be accomplished for those residents found to have been affected by this practice? On the Activities Care Plan for Resident # 60 was added to reflect the resident□s individualized activity preferences 2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken. On , MDS Coordinator/designee completed an audit of current Resident□s Activity care plans to ensure that they were in place on admission. 3) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? On , MDS Coordinator/designee completed education with the Activity Director on requirements for Activity care plans to be initiated on Admission. 4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place? DNS/designee to complete a random audit of Activity care plans weekly x 4 weeks and then monthly x 2 months. Audit will be looking for Activity care plans initiated on Admission and updated as needed. Findings will be reported at the monthly QA/Risk management committee until such time substantial compliance has been met and committee recommends	

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F 656	Continued From page 5 on at 1:23 PM, she reported that Resident #60 was seen by and . He was able to be in a wheelchair with from staff, but did not get out of his room. He was later admitted to hospice and taken off rehab. Review of the Minimum Data Set for Resident #60 dated revealed that it is somewhat important for him to choose his favorite activities. Review of the Individual Resident Activities sheet showed that Resident #60 participated in: viewing television, and conversing, for the months of and . In an interview conducted with the Activity Director on at 1:43 PM, she reported that r]Resident #60 participated in activities. When asked if there was a plan for 1 on 1 she said no. She further stated that Resident #60 refused to go outdoors when asked or encouraged. She confirmed that not creating a care plan on activities was an oversight on her part. Record review of the care plan initiated on for activities showed that Resident #60 will have the calendar at his bedside so he is able to read it easier. He will have room visits for coffee and conversation as well as using a wheelchair to attend activities that he may like to attend.	F 656	quarterly monitoring when conducting quality systems review by the RDCO.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		

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F 684	Continued From page 6 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to clarify need for , medication and notify MD and document why medication held for 1 of 5 residents observed for medication administration observation (Resident #60). The findings included: Resident #60 was admitted to the facility on with diagnoses included and A review of the resident's Medication Administration Record (MAR) revealed Resident #60 received (medication to increase ,) 2.5 milligrams two times a day at 9:00 AM and 9:00 PM. Further review of the MAR revealed the medication was held 9:00 AM on , , and . There was no documentation as to why the medication was held, or the physician being notified. Further review of Resident #60's MAR revealed the resident had vital signs documented every shift. Resident #60's , ranged from - . There were no parameters to administer or hold the medication. An interview was conducted with the Unit	F 684	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole purpose of compliance with State and Federal Regulations. F684 (D) - Quality of Care 1) What corrective action will be accomplished for those residents found to have been affected by this practice? Resident #60□s Physician was notified and a Medication Error Report completed. 2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken. On , DON/designee completed a comprehensive audit of Residents on Medications to ensure the medication was administered complaint with Physician□s Orders. 3) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? " By the DON/designee completed Re-education with the Licensed Nursing Staff on the	

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F 684	Continued From page 7 Manager (UM) on . . . . . at 2:00 PM. The UM verified when a medication is held, the reason should be documented and the physician notified. The UM further stated the physician should have been contacted to inquire if the resident still needed the medication or for parameters to hold the medication.	F 684	administration of medications compliant with Physician s Orders. 4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place? " DON/designee will weekly audit 5 random Residents on medications to ensure . medications are administered compliant with Physician s Orders weekly x 4 weeks and then monthly x 2 months. " Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to provide a safe environment for 6 residents documented as an elopement risk, one of which is also a smoker. The residents included Resident #10, #26, #47, #53, #66, and #285.	F 689	.Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole purpose of compliance with State and	

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F 689	Continued From page 8 Findings included: On at 3:30 PM an attempt was made to locate a resident for an interview on the second floor. The Unit Manager suggested that the resident may be outside of the building either on the front or patio. At the front patio there were several residents. Approximately 10 from the residents was an open gate that lead to an open door to the stairwell and an inner door. The inner door was unlocked, which allowed for easy access into the facility. A check of the open door from inside the facility revealed it was unlocked and the exit alarm was not active. Further observation revealed written signs that indicated that the exterior door was not to be left opened. The patio was then visited. An open gate leading to the parking lot was observed. A continued walk around the perimeter was performed, where it was noted that there were no security cameras and there was easy access to the street in front of the facility. These observations were reported to the Team Leader and another team member, both of whom made all of the same observations at that time. The Facility Administrator and the of Maintenance were notified. The of Maintenance walked the perimeter of the facility with the surveyor and observed the issues described. A test of the Guard system was conducted by the Administrator with the of Maintenance present. The Guard sensor failed to set off an alarm at the door in question. The same Guard sensor worked on all other doors. The Administrator and of Maintenance both acknowledged this was a serious safety issue	F 689	Federal Regulations. F689 (E) - Free of Accident Hazards/Supervision/Devices 1) What corrective action will be accomplished for those residents found to have been affected by this practice? Upon discovery of need, Staff members were assigned 24/7 to monitor the affected door 1:1 until repairs were completed. 2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken. On , ED/designee completed a comprehensive audit of Facility egress doors to ensure no other doors were affected. 3) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? " By , the ED/designee completed Re-education with the Maintenance Director and Maintenance Assistants on the components of F689 with emphasis on Guard doors and ensuring safe Facility environment. 4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place? " Maintenance Director/designee to randomly audit guard doors to ensure functionality weekly x 4 weeks and then monthly x 2 months. " Findings will be reported at the	

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F 689	Continued From page 9 and immediately started to work on correcting the problem. Photographic evidence obtained.	F 689	monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso- and tubes, both , and endoscopic , and fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body or desirable body range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review the facility failed to maintain acceptable parameters of nutritional status, for 1 of 5 sampled residents (Resident #65). The findings included:	F 692	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole	

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F 692	Continued From page 10 Review of the record revealed Resident #65 was admitted on with diagnoses of , legal , , and . Review of Resident #65's are as following: , , , , and , . Review of the nutrition progress note dated revealed that Resident #65 is readmitted from the hospital after a placement. His is currently receiving 5 cans of feeding formula that is providing: 1500 calories, 75 grams of protein and 1020 milliliters of fluids. Resident #65 is at suboptimal nutrition related to current regimen not meeting estimated needs as per dietitian. Estimated nutritional needs are as following: 1675-2010 calories/day, 67-80 grams/protein a day and 1675-2010 millimeter/day of fluids. The dietitian recommended to increase the regimen to 6 cans a day which will provide: 1800 calories/day, 90 grams of protein and 1224 milliliters of water. His Ideal Body is noted at . Review of the Dietary Communication Form to the physician dated revealed the dietitian recommendations for 6 cans of 1.2 per day. Further record review of the Medication Administration Record (MAR) for Resident #65 for the month of , showed that he received 5 cans of from to and not the recommended regimen by the dietitian. Further record review of the nutrition progress note dated revealed that there was a recent increase in bolus feeding to 6 cans of per day. Progress note dated	F 692	purpose of compliance with State and Federal Regulations. F692 (D) Nutrition/Hydration Status Maintenance 1) What corrective action will be accomplished for those residents found to have been affected by this practice? Resident #65 Physician was notified and Resident was reassessed by the Dietician; No loss was noted and Physician s Order was updated to include Registered Dietician s recommendations. 2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken. On , DON/designee completed an audit of current Residents with to ensure accuracy of feed. 3) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? " By the DON/designee completed Re-education with the Licensed Nursing Staff regarding Registered Dietician s recommendations. 4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place? " DON/designee will weekly audit 5 random Residents to ensure accuracy of Feed Orders weekly x 4 weeks and then monthly x 2 months. " Findings will be reported at the monthly QA/Risk management meeting	

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(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 692	Continued From page 11 showed that Resident #65 had been changed to Isosurce 1.5 feeding formula at 65 milliliters times 20 hours and was providing: 1950 calories/day, 88 grams/protein a day, and 988 millimeters of fluids. In an interview on at 3:48 PM with Staff A, she reported that Resident #65 is at high nutritional risk. She confirmed that the regimen needed to be increased to 6 cans a day. When asked by surveyor as to what is the protocol for communicating with the doctor, she stated that they put the recommendation in the chart and it gets picked up by nursing. According to Staff A, nursing calls the doctor with the dietitian's recommendations. If the physician did not see the recommendations then the dietitian needs to contact the physician directly. In an interview on at 4:00 PM with Staff B, he reported that the recommendations by the dietitian on was never picked up by nursing. When asked as to why the recommendations were never implemented Staff B reported that he didn't know. Review of the Change Communication Form dated by Staff A showed that Resident #65 had a % in 90 days. Staff A is requesting the physician to consider future management, and order lab with next set of labs. Resident #65 is with ( ) of 20.0 which is	F 692	until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		

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F 755	Continued From page 12 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to accurately reconcile medications for 2 out of 4 carts reviewed for reconciliation (Resident #60 and Resident #54). Facility failed to have prescribed medication on in a timely manner for 1 of 5 residents	F 755	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole purpose of compliance with State and	

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F 755

Continued From page 13

observed for medication administration (Resident #78).

The findings included:

1. A reconciliation was conducted with Staff M, a Registered Nurse (RN), on at 11:30 AM for Resident #60. Resident #60 had a physician order dated for 15 milligrams, give two 7.5 mg tablets= 15 mg every 6 hours as needed for .

A review of Resident #60's Controlled Medication Utilization Record documented 15 mg to give tablet (7.5 mg) every 6 hours as needed for breakthrough (different from the physician order of two 7.5 mg tablets=15 mg). The bubble packet of was packaged with tabs. The medication was signed out as one tablet removed on at 12:00 AM and 6:30 AM, on at 12:00 AM and 6:30 AM, on at 12:00 AM and 6:00 AM.

A review of Resident #60's Medication Administration Record (MAR) did not reveal any documentation of administration of 15 mg (2 of 7.5 mg tablets) of on . On it was documented as administered at 9:21 AM (not documented on the Controlled Medication Utilization Record).

2. A reconciliation was conducted with Staff L at 11:45 AM for Resident #54. A review of Resident #54's Controlled Medication Utilization Record documented 5 mg every 12 hours as needed. It was documented as removed on at 9:00 AM, on at 12:05 PM, on at 6:30 AM and 9:00 PM, on at 6:20 PM, on at 9:57 AM and 6:00 PM,

F 755

Federal Regulations.

F755D Pharmacy Svcs/Procedures/Pharmacist/Records

1) What corrective action will be accomplished for those residents found to have been affected by this practice?
Resident #54s Physician was notified. And the count was reconciled.
Resident #60s Physician was notified of removal of the discontinued medication.
There was not a Resident #78 listed on the Sample List of Residents provided to the Facility. However through review of Residents MARs we did identify a Resident whose medications match the description of the medications addressed in F759 in #1 of the findings listed. That Resident was discharged home on .

Staff M and Staff L were re-educated regarding reconciliation.

2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken.
On , DON/designee completed an audit of Residents controlled substance counts to ensure accuracy. And an audit was conducted of Med to MAR to ensure availability of medications.

3) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur?
" By , the DON/designee completed Re-education with the Licensed Nurses regarding reconciliation and availability of medications.

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F 755	Continued From page 14 on at 11:30 AM, and on at 4:36 PM. A review of the resident's MAR revealed documentation of administration of 2 mg of administered on at 10:40 AM, on at 12:05 PM, and on at 9:47 AM. A review of Resident #54's physician orders revealed an order for 5 mg every 12 hours as needed for , that was discontinued on . An order dated for 2 mg every 24 hours as needed for , for 7 days (until). A review of the facility's policy on Disposal/Destruction of Expired or discontinued Medications dated documented : Once an order to discontinue a medication is received, facility staff should remove this medication from the resident's medication supply. The above was discussed with the Unit Manager, who confirmed the discrepancies. 3. A medication administration observation was conducted with Staff L on at 9:15 AM for Resident #60. Staff L stated the resident was to be administered (, medication) 25 mg, which was not on . Staff L stated she would order it from the pharmacy. An interview was conducted with the Unit Manager (UM) on at 11:45 AM. The UM stated it was the nurse's responsibility to reorder medications from pharmacy when a resident gets down to a 5 day supply left.	F 755	4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place? " DON/designee to randomly audit controlled substance counts for 5 random Residents weekly x 4 weeks and then monthly x 2 months. And audit 5 random Residents to ensure medication availability weekly x 4 weeks and then monthly x 2 months. " Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.	

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F 759	Continued From page 15	F 759		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to be free of medication error rate of 5% or more. There were a total of 5 medication errors out of 29 opportunities. The medication error rate was 33%, and affected Residents #78 and 60. The findings included: 1. A medication administration observation was conducted with Staff L, a Registered Nurse (RN), on at 9:20 AM. Staff L prepared medication for Resident #78. A total number of 5 pills to be given was verified by Staff L. Included in the medication to be administered to Resident #78, was 500 milligrams x 2 tabs. Staff L stated the resident also had ( ) 600 milligrams ordered to administer at that time, but it was to be administered 30 minutes before morning and evening meals. Staff L stated she would give the medication before lunch, as the resident had just finished breakfast. Staff L administered the medications to Resident #78. Staff L confirmed with the surveyor there was no other medication due to administer at this time. A medication reconciliation was conducted after medication administration observation was	F 759	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole purpose of compliance with State and Federal Regulations. F759D Free of Medication Errors Rates of 5% or More 1) What corrective action will be accomplished for those residents found to have been affected by this practice? Staff L (RN) received immediate re-education from DON/designee regarding medication pass. Physician was notified. Staff M received immediate re-education from DON/designee regarding completion of medication pass compliant with Physician□s Orders. Physician was notified. Resident #60□s Physician was notified of the Resident□s need for an additional There was not a Resident #78 listed on the Sample List of Residents provided to the Facility. However through review of	

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F 759	Continued From page 16 completed. A review of Resident #78's physician orders revealed an order for 600 mg x 2 tablets daily (not the 500 mg x 2 that was administered). Further review of Resident #78's orders revealed an order for 600 mg two times a day at 9:00 AM and 5:00 PM. There was no specification for the medication to be given 30 minutes before meals. Further review of the resident's orders revealed an order for (a) 30 mg to be given daily at 9:00 AM, which the surveyor did not observe given to Resident #78. An interview was conducted with Staff L and the Unit Manager on at 11:20 AM. Staff L acknowledged the wrong dosage of was given. Staff L further acknowledged the should have been administered. Staff L stated she had administered Resident #78 earlier in the morning. 2. A medication administration observation was conducted with Staff M, a Registered Nurse (RN), on at 9:40 AM. Staff M prepared medication for Resident #60. A total number of 7 pills and 1 patch to be given was verified by Staff M. Included in the medication to be administered to Resident #60, was a softener 100 mg. Staff M stated the resident had (increasing medication) 2.5 mg ordered to be administered at that time, but the resident's was elevated. Staff M stated she would hold the medication. Staff M administered the medications to Resident #60. Staff M confirmed with the surveyor there was no other medication due to administer at that time.	F 759	Residents MARs we did identify a Resident whose medications match the description of the medications addressed in F759 in #1 of the findings listed. That Resident was discharged home on . 2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken. Staff Nurses L and M will not pass medications until thay have completed a medication pass observation completed by the Pharmacy Nurse. 3) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? " By , the DON/designee completed Re-education with the Licensed Nurses regarding medication administration compliant with Physician Orders. 4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place? " DON/designee to randomly audit 5 random Medication Pass Observations to ensure medications administered compliant with Physicians Orders weekly x 4 weeks and then monthly x 2 months. " Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.	

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F 759	Continued From page 17 A medication reconciliation was conducted after medication administration observation was completed. A review of Resident #60's physician orders revealed an order for .... softener 200 mg (not 100 mg that was administered) daily at 9:00 AM. Further review of Resident #60's orders revealed an order for 2.5 mg twice a day for (low). There were no parameters given to hold the medication. The physician was not notified. An interview was conducted with Staff M and the Unit Manager on at 11:30 AM. Staff M acknowledged the wrong dose of .... softener was administered to Resident #60. Staff M further acknowledged there were no parameters to hold the . The medication should have been administered, or the physician notified.	F 759		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide therapeutic diets that were prescribed by the attending	F 808	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of	

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F 808	Continued From page 18 physician for 2 of 5 sampled residents (Resident #61 and Resident #2). The findings included: 1. Review of the record revealed Resident #61 was admitted on with diagnoses of: , , and , failure. An order was noted for pureed diet with nectar thick consistency dated . Another order dated showed house supplement 4 times a day for supplements. Further record review of the percentage intake of meals showed that Resident #61 ate 0-25% of his meals from -. In an observation conducted on at 12:30 PM Resident #61 was observed with his lunch tray at the bedside. The lunch tray did not have any of the supplements as prescribed by the attending physician. The lunch meal ticket did not show any supplements on the ticket for house supplements. 2. Review of the record for Resident #20 showed that he was admitted on with diagnosis of: type 2 , , and . Resident #20 is on regular, no added salt nectar thick liquids with frozen nutritional treats for lunch and dinner. An order was noted for Resource 2.0 (nutritional supplements) 2 times a day. Record review of the progress note by the dietitian dated revealed that Resident #20 remains on nectar thick liquid diet with frozen treats and house supplement 3 times a day. In an observation conducted on at 12:35	F 808	the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole purpose of compliance with State and Federal Regulations. F808D Therapeutic Diet Prescribed by Physician 1) What corrective action will be accomplished for those residents found to have been affected by this practice? Resident #61s and Resident #20s Physicians Orders were updated to include supplements. 2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken. On , DON/designee completed audit of current Residents on nutritional supplements to ensure they are receiving supplements as ordered. 3) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? " By , the DON/designee completed Re-education with the Registered Dietician and Nursing Staff regarding provision of supplements as ordered by the Physician. 4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place? " DON/designee to randomly audit 5 Residents on supplements weekly x 4 weeks and then monthly x 2 months to ensure Residents ordered supplements	

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F 808	Continued From page 19 PM Resident #20 was observed with his lunch tray at the bedside. The lunch tray consisted of: meat lasagna, vegetable medley and a toast. There were no supplements on the lunch tray for: frozen treats and Resource 2.0 as prescribed by the attending physician. The lunch meal ticket did not show any supplements on the ticket. 3. An interview was conducted with Staff C on at 12:59, she reported that Resident #61 has not been eating well, and that she placed a call to notify his primary care physician. When asked by surveyor as to why Resident #61 and Resident #20 did not get their supplements, she reported that it comes from the kitchen and its placed on the food trays. She further stated that she will call the kitchen to verify as to why they did not get their supplements. In an interview conducted on at 1:00 PM with Staff A, she reported that the supplements that come from the kitchen are: house shakes, frozen treats, and magic cups. The supplements are then written on the meal ticket and provided on the meal trays. She further stated that Resource 2.0 and Pro-stat (supplements) are kept in the pantry and are to be given by nursing. In an interview with Director of Nursing on at 1:00 PM, she reported that there are no policies in regards to nutritional supplements.	F 808	are receiving them. " Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		

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F 812	Continued From page 20 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interviews and record review, the facility failed to keep food safety requirements in accordance with professional standard of food service safety, that include: holding foods at regulatory temperature, failure to properly clean equipment/preparation areas after each use, and failure to have kitchen's equipment in working condition. The findings included: 1. During the kitchen/food service observation tour conducted in the main kitchen on at 8:45 AM accompanied with the facility's CDM (Certified Dietary Manager) the following were noted: The hood in the main production area as well as the two lights underneath the hood were not working. The cook reported that the hood has not been working for a long time and is not in use when cooking in the kitchen.	F 812	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole purpose of compliance with State and Federal Regulations. F812F Food Procurement, Store/Prepare/Serve-Sanitary 1) What corrective action will be accomplished for those residents found to have been affected by this practice? Areas identified in the 2567 were immediately addressed to ensure compliance with food safety requirements in accordance with professional standard of food service safety. And Lunch bags were purchased with ice packs. 2) How will you identify other residents	

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Broken tiles were noted on the floor in the main kitchen.

The main kitchen by the front area, surveyor noted debris/dirt as well as empty boxes all over the floor.

A large garbage bin was noted in the main production area without a lid. The CDM reported that is not used by staff.

The walk in refrigerator had some dirt and dust on the ceiling around the fan area. Closer look revealed rust as well.

The bathroom floor as well as the outside of the bathroom's area revealed dirt/debris on the floor.

The dry storage area outside the main kitchen had a dripping cooling unit with ice forming around it. A clear bucket was on the floor underneath the unit to collect the dripping water from the fan.

The CDM acknowledged all the findings.

2. An interview was conducted with Resident #1 who reported that he goes to ... 3 times a week and each session takes about 4 hours outside the facility. According to him, the lunch bag that is provided is usually a ham and cheese sandwich and it is never in an ice-pack or insulated.

Review of the record revealed that Resident #1 is with diagnoses of: ..., and . Further record review showed that he is receiving ... on

F 812

having the potential to be affected by the same practice, and what corrective action will be taken.
On , CDM/designee completed audit of kitchen with respect to sanitation, such as clean equipment/preparation areas after use and maintenance of kitchen's equipment in working condition.
On ... DON/designee conducted audit of outpatient Residents to ensure ... packs provided with lunch bags.
3) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur?
By ..., the ED/designee completed Re-education with the Kitchen Staff regarding compliance with food safety requirements in accordance with professional standard of food service safety, as well as, provision of lunch bags with ice packs to Outpatient ... Residents.
4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place?
" ED/designee to audit kitchen weekly x 4 weeks and then monthly x 2 months to ensure kitchen equipment in working condition, staff have properly cleaned equipment/preparation areas after each use, and Residents are provided lunch bags with ice packs.
" Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when

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F 812	Continued From page 22 Monday, Wednesday, and Friday. In an observation conducted on . . . . . . at 9:20 AM Resident #1 was noted in the hallway on a stretcher on his way out to . . , . . Closer observation revealed a lunch bag with two ham and cheese sandwiches, cookies and a bottle of water. The food was placed in simple Ziploc bag with no ice pack. Surveyor discussed the issues with the Certified Dietary manager, and Staff A regarding holding . . . foods in the appropriate temperatures.	F 812	conducting quality systems review.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop appropriate plans of actions to correct identified deficiencies related to pest control. The findings included: The facility was cited for not having an effective pest control program in the last standard survey dated . The facility was found to have deficient practice during the standard recertification survey related to not having an effective pest control program.	F 867	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole purpose of compliance with State and Federal Regulations. F867D QAPI/QAA Improvement Activities 1) What corrective action will be accomplished for those residents found to have been affected by this practice? Pest control was immediately contacted,	

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F 867	Continued From page 23 An interview was conducted with the facility plant operations manager on at 1:40 PM. The plant manager stated they had implemented a pest control log where sightings of roaches were logged in. The pest control company comes monthly and as needed. With each sighting, the pest control company was to be called out to the facility. A review of the pest control log revealed the pest control company had come to the facility five times in The Plant Operation Manager further stated they would now have the pest control company come out to the facility weekly, and rearrange the residents so a deep clean and treatment for roaches could be done. An interview was conducted with the Interim Nursing Home Administrator (NHA) and Regional Vice President of Operations on at 1:40 PM. The NHA stated the facility was going through a transitional stage.	F 867	upon arrival their serviced the identified resident rooms, as well as dining and nourishment rooms. 2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken. On an Ad Hoc QAA/QAPI Committee Meeting was held to discuss Survey results of Annual Survey with enhanced emphasis placed upon the implementation and monitoring of corrective action plans. 3) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? By , the RVPO/designee completed education with the Executive Director and QAA Committee regarding implementation and monitoring of Quality Assurance and Performance Improvement Activities. 4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place? " ED/designee to review, during monthly scheduled QAA Committee Meetings, results of corrective action plans in place. " Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.	
F 925	Maintains Effective Pest Control Program	F 925		

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F 925 SS=F	Continued From page 24 CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to have an effective pest control program. The findings included: 1). During the Resident Council meeting, on at 2:30 PM, Resident #70 in stated that he had seen roaches in his bathroom. During a tour of the resident's room, on at 5:11 PM, this surveyor observed one roach on the floor under the sink in the resident's restroom and live roaches, in all stages of life and too numerous to count, in the resident's room under and behind a piece of furniture used for keeping resident's personal clothing and belongings. On at 5:40 PM, the Director of Maintenance was made aware of the roaches by way of this surveyor showing him the roaches in Resident #70's room and restroom. During an interview, the Director of Maintenance stated that he was aware of the problem and further stated, "this is one of the four rooms that have been brought to our attention. I will call pest control and have them come out as soon as possible. 2). During an observation of the Restorative Dining Room, on at 7:11 AM, this surveyor observed 4 roaches and 8 live mature and , roaches in the restorative	F 925	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole purpose of compliance with State and Federal Regulations. F925F Maintains Effective Pest Control Program 1) What corrective action will be accomplished for those residents found to have been affected by this practice? Pest control was immediately contacted, upon arrival the Pest Control , serviced the identified resident rooms, as well as the dining and nourishment rooms. 2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken. On ED/designee conducted pest control audit of the Facility. No additional pests were identified. 3) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? On , ECO Lab completed in-service with Facility Department Heads regarding immediately reporting the identification of	

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F 925

Continued From page 25

dining room and one . . . . roach on the floor in the hall just outside of the entrance to the Restorative Dining Room.

During an interview with the Dietary Manager, on at 7:23 AM, she stated that there had been no reports of roaches from staff or residents. She further stated that (pest control) comes every two weeks, including during the previous weekend, to treat the kitchen and dining rooms.

During an interview with the Interim Administrator, the Corporate Vice President and the Director of Maintenance, on . . . . . . at 7:38 AM, the Interim Administrator stated that they are going to "close the dining room, give it a deep cleaning and pest control should be here around 8:00. We are going to keep it closed at least for breakfast."

On . . . . . . at 11:38 AM during an interview with Service , from (pest control), he stated, "If some one reports that they have seen a pest, they log it into the (pest control company) log book and call the 1800 number and then I have 24 hours to respond. I usually come out the same day or the next morning. I treat and document in the log book. When we have activitiy we treat the room, I follow up with the Maintenance Director. After I treat, I have 24-48 hours to show up/follow up. We are going to treat one unit each week, even if there is no activity. The facility is moving the residents for the time that I am spraying and treating their rooms. The common areas are treated at night when there is nobody around, they know how to prepare for us to come in at night and they know when we are going to come in for the food and beverage areas including both dining rooms and the kitchen.

F 925

pests in the Facility, give specific details about the location of the sighting, and logging the sighting in the Pest Control Log Binder located at the Receptionist s Desk. Additionally, Pest Control Log Binders have also been placed at 1st floor Nursing Station, 2nd floor Nursing station, and Seaside Nursing Station on 2nd floor.
4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place?
" ED/designee to audit Pest Control Binders weekly x 4 weeks and then monthly x 2 months to ensure compliance with pest control program.
" Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.

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F 925 Continued From page 26 F 925

Anything that can be contaminated when we flush (crack and crevice) is covered, we bait, we dust and do residual spray. They (the facility staff) clean up when they come in. It seems to come and go. The problem that I run into is that the residents have to leave the rooms while I am treating the room. I will be ... tomorrow to follow up because I was here today."

During a follow up interview, on at 11:36 AM, with the Service ... from (pest control), he stated, "When there is a room with roaches you will find them in the dresser and the drawers. I ask them to prep the rooms by moving the drawers and items from the furniture. Recently, they haven't been prepping properly by making the room treatable for me to go in and do a thorough treatment. I come out once a month for regular service and whenever they request. The kitchen is treated overnight."

3) In an observation conducted on ... at 9:15 AM in the main dining room on the second floor, revealed the following: a buffet table/beverage counter was observed in the corner of the dining room. In a closer observation it had 3 drawers that were noted to be with pests/roaches in all stages of life. Another drawer was noted with dirty/debris linens and a kitchen mitten. The second drawer to the right had an egg sandwich in a foil paper with a cup of oatmeal, and a cup of opened sugar. The top part of the counter had spilled liquid which may be coffee, but surveyor was not sure. Staff A and the Certified Dietary manager acknowledged the findings and removed the linen and the food from the counter and draws.

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F 925	Continued From page 27 4) In an observation conducted on . . . . at 9:25 AM in the first floor's pantry revealed two drawers with pests/roaches in it. Closer observation showed dirt and open jelly packages in the drawers. A tray was noticed on top of the counter that had fruits and packages of crackers in close proximity to the pests. Surveyor pulled the refrigerator to have a closer look behind. There were pests/roaches at all stages of life running on the walls and on the floor behind and under the refrigerator. Staff B and a pest control company staff acknowledged the findings.	F 925		

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N 000	INITIAL COMMENTS An unannounced Relicensure survey was conducted on ... to ... at Avante at Boca Raton, Inc. The facility had deficiencies at the time of the visit.	N 000		
N 054 SS=D	59A-4.107(5), FAC Follow Physician Orders All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to be free of medication error rate of 5% or more. There were a total of 5 medication errors out of 29 opportunities. The medication error rate was 33%, and affected Residents #78 and 60. The findings included: 1. A medication administration observation was conducted with Staff L, a Registered Nurse (RN), on at 9:20 AM. Staff L prepared medication for Resident #78. A total number of 5 pills to be given was verified by Staff L. Included in the medication to be administered to Resident #78, was 500 milligrams x 2 tabs. Staff L stated the resident also had ( ) 600 milligrams ordered to administer at that time, but it was to be administered 30 minutes before morning and	N 054	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole purpose of compliance with State and Federal Regulations. N054 Follow Physicians Orders 1) What corrective action will be accomplished for those residents found to have been affected by this practice? Staff L (RN) received immediate re-education from DON/designee regarding medication pass. Physician was notified. Staff M received immediate re-education from DON/designee regarding completion of medication pass compliant with	

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N 054	Continued From page 1 evening meals. Staff L stated she would give the medication before lunch, as the resident had just finished breakfast. Staff L administered the medications to Resident #78. Staff L confirmed with the surveyor there was no other medication due to administer at this time. A medication reconciliation was conducted after medication administration observation was completed. A review of Resident #78's physician orders revealed an order for 600 mg x 2 tablets daily (not the 500 mg x 2 that was administered). Further review of Resident #78's orders revealed an order for 600 mg two times a day at 9:00 AM and 5:00 PM. There was no specification for the medication to be given 30 minutes before meals. Further review of the resident's orders revealed an order for (a) 30 mg to be given daily at 9:00 AM, which the surveyor did not observe given to Resident #78. An interview was conducted with Staff L and the Unit Manager on at 11:20 AM. Staff L acknowledged the wrong dosage of was given. Staff L further acknowledged the should have been administered. Staff L stated she had administered Resident #78 earlier in the morning. 2. A medication administration observation was conducted with Staff M, a Registered Nurse (RN), on at 9:40 AM. Staff M prepared medication for Resident #60. A total number of 7 pills and 1 patch to be given was verified by Staff M. Included in the medication to be administered to Resident #60, was a softener 100 mg.	N 054	Physician□s Orders. Physician was notified. Resident #60□s Physician was notified of the Resident□s need for an additional There was not a Resident #78 listed on the Sample List of Residents provided to the Facility. However through review of Residents MARs we did identify a Resident whose medications match the description of the medications addressed in F759 in #1 of the findings listed. That Resident was discharged home on 2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken. Staff Nurses L and M will not pass medications until thay have completed a medication pass observation completed by the Pharmacy Nurse. 3) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? " By , the DON/designee completed Re-education with the Licensed Nurses regarding medication administration compliant with Physician Orders. 4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place? " DON/designee to randomly audit 5 random Medication Pass Observations to ensure medications administered compliant with Physician□s Orders weekly x 4 weeks and then monthly x 2 months. " Findings will be reported at the	

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N 054	Continued From page 2 Staff M stated the resident had (increasing medication) 2.5 mg ordered to be administered at that time, but the resident's was elevated. Staff M stated she would hold the medication. Staff M administered the medications to Resident #60. Staff M confirmed with the surveyor there was no other medication due to administer at that time. A medication reconciliation was conducted after medication administration observation was completed. A review of Resident #60's physician orders revealed an order for softener 200 mg (not 100 mg that was administered) daily at 9:00 AM. Further review of Resident #60's orders revealed an order for 2.5 mg twice a day for (low). There were no parameters given to hold the medication. The physician was not notified. An interview was conducted with Staff M and the Unit Manager on at 11:30 AM. Staff M acknowledged the wrong dose of softener was administered to Resident #60. Staff M further acknowledged there were no parameters to hold the . The medication should have been administered, or the physician notified. Class III	N 054	monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.	
N 072 SS=D	59A-4.109(2), FAC; 400.021(18), FS Comprehensive Care Plans 59A-4.109(2) FAC The nursing home licensee develop a comprehensive care plan for each resident that	N 072		

Agency for Health Care Administration

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N 072	Continued From page 3	N 072		

includes measurable objectives and timetables to meet a resident's medical, nursing, mental and [illegible] needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment.

400.021(18) FS
"Resident care plan" means a written plan developed, maintained, and reviewed not less than quarterly by a registered nurse, with participation from other facility staff and the resident or his or her designee or legal representative, which includes a comprehensive assessment of the needs of an individual resident, the type and frequency of services required to provide the necessary care for the resident to attain or maintain the highest practicable physical, mental, and [illegible] well-being, a listing of services provided within or outside the facility to meet those needs, and an explanation of service goals.

This Statute or Rule is not met as evidenced by:
Based on interviews, record review, and observations the facility failed to implement a comprehensive person-centered care plan to meet a resident's mental and [illegible] needs for 1 of 14 residents reviewed for care plans (Resident #60).

The findings included:

In an interview conducted on [illegible] at 1:00 PM, Resident #60 stated that he has not been out

Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole purpose of compliance with State and Federal Regulations.

N072 - Comprehensive Care Plans

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N 072	Continued From page 4 of bed since he was admitted. He further stated that he would like to participate in activities but is not able to read the Activity Schedule that is posted on the wall across from his bed. He further reported that he was never seen by the Activity Director while in the facility. During this interview, Resident #60's wife reported that he has not been out of bed since he was admitted. She further stated that they are waiting on a wheelchair to be able to get out of bed, and that the administrator told them that a new shipment of wheelchairs are expected to come in. Record review revealed that Resident #60 was admitted on with diagnoses of: following a infraction effecting the left non-dominant side. He was admitted to hospice on . Review of the care plan dated revealed that Resident #60 is at risk for self-care performance and balance. He has limited range of motion and he uses side of rails to assist him with bed mobility. Closer review of the care plan showed no plan for activities created by the activity director. In an interview conducted on at 1:17 PM with Staff B, Unit Manager, he reported that Resident #60 has no order that restricts him from getting out of bed. He further reported that there is no care plan done for activities. Staff B stated that he has not seen Resident #60 out of bed in the past few weeks. In an interview conducted with the Rehab Director on at 1:23 PM, she reported that Resident #60 was seen by and . He was able to be in a	N 072	1) What corrective action will be accomplished for those residents found to have been affected by this practice? On the Activities Care Plan for Resident # 60 was added to reflect the resident's individualized activity preferences 2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken. On , MDS Coordinator/designee completed an audit of current Resident's Activity care plans to ensure that they were in place on admission. 3) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? On , MDS Coordinator/designee completed education with the Activity Director on requirements for Activity care plans to be initiated on Admission. 4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place? DNS/designee to complete a random audit of Activity care plans weekly x 4 weeks and then monthly x 2 months. Audit will be looking for Activity care plans initiated on Admission and updated as needed. Findings will be reported at the monthly QA/Risk management committee until such time substantial compliance has been met and committee recommends quarterly monitoring when conducting quality systems review by the RDCO.	

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N 072	Continued From page 5 wheelchair with from staff, but did not get out of his room. He was later admitted to hospice and taken off rehab. Review of the Minimum Data Set for Resident #60 dated revealed that it is somewhat important for him to choose his favorite activities. Review of the Individual Resident Activities sheet showed that Resident #60 participated in: viewing television, and conversing, for the months of and . In an interview conducted with the Activity Director on at 1:43 PM, she reported that r]Resident #60 participated in activities. When asked if there was a plan for 1 on 1 she said no. She further stated that Resident #60 refused to go outdoors when asked or encouraged. She confirmed that not creating a care plan on activities was an oversight on her part. Record review of the care plan initiated on for activities showed that Resident #60 will have the calendar at his bedside so he is able to read it easier. He will have room visits for coffee and conversation as well as using a wheelchair to attend activities that he may like to attend. Class III	N 072		
N 093 SS=D	59A-4.112(4), FAC Controlled Drug - Accounting The pharmacist shall determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	N 093		

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AVANTE AT BOCA RATON, INC.	1130 NW 15TH STREET BOCA RATON, FL 33486

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N 093	Continued From page 6 This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to accurately reconcile medications for 2 out of 4 carts reviewed for reconciliation (Resident #60 and Resident #54). Facility failed to have prescribed medication on in a timely manner for 1 of 5 residents observed for medication administration (Resident #78). The findings included: 1. A reconciliation was conducted with Staff M, a Registered Nurse (RN), on at 11:30 AM for Resident #60. Resident #60 had a physician order dated for 15 milligrams, give two 7.5 mg tablets= 15 mg every 6 hours as needed for . A review of Resident #60's Controlled Medication Utilization Record documented 15 mg to give tablet (7.5 mg) every 6 hours as needed for breakthrough , (different from the physician order of two 7.5 mg tablets=15 mg). The bubble packet of , was packaged with tabs. The medication was signed out as one tablet removed on at 12:00 AM and 6:30 AM, on at 12:00 AM and 6:30 AM, on at 12:00 AM and 6:00 AM. A review of Resident #60's Medication Administration Record (MAR) did not reveal any documentation of administration of 15 mg (2 of 7.5 mg tablets) of on . On it was documented as administered at 9:21 AM (not documented on the Controlled Medication Utilization Record). 2. A reconciliation was conducted with	N 093	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole purpose of compliance with State and Federal Regulations. N093 Controlled Drug - Accounting 1) What corrective action will be accomplished for those residents found to have been affected by this practice? Resident #54's Physician was notified. And the count was reconciled. Resident #60's Physician was notified of removal of the discontinued medication. There was not a Resident #78 listed on the Sample List of Residents provided to the Facility. However through review of Residents MARs we did identify a Resident whose medications match the description of the medications addressed in F759 in #1 of the findings listed. That Resident was discharged home on Staff M and Staff L were re-educated regarding reconciliation. 2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken. On , DON/designee completed an audit of Residents controlled substance counts to ensure accuracy. And an audit was conducted of Med to MAR to ensure availability of medications. 3) What measures will be put into place or what systemic changes will you take to	

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N 093	Continued From page 7 Staff L at 11:45 AM for Resident #54. A review of Resident #54's Controlled Medication Utilization Record documented 5 mg every 12 hours as needed. It was documented as removed on at 9:00 AM, on at 12:05 PM, on at 6:30 AM and 9:00 PM, on at 6:20 PM, on at 9:57 AM and 6:00 PM, on at 11:30 AM, and on at 4:36 PM. A review of the resident's MAR revealed documentation of administration of 2 mg of administered on at 10:40 AM, on at 12:05 PM, and on at 9:47 AM. A review of Resident #54's physician orders revealed an order for 5 mg every 12 hours as needed for , that was discontinued on . An order dated for 2 mg every 24 hours as needed for , for 7 days (until). A review of the facility's policy on Disposal/Destruction of Expired or discontinued Medications dated documented : Once an order to discontinue a medication is received, facility staff should remove this medication from the resident's medication supply. The above was discussed with the Unit Manager, who confirmed the discrepancies. 3. A medication administration observation was conducted with Staff L on at 9:15 AM for Resident #60. Staff L stated the resident was to be administered (medication) 25 mg, which was not on . Staff L stated she would order it from the pharmacy.	N 093	ensure that the practice does not reoccur? " By , the DON/designee completed Re-education with the Licensed Nurses regarding reconciliation and availability of medications. 4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place? " DON/designee to randomly audit controlled substance counts for 5 random Residents weekly x 4 weeks and then monthly x 2 months. And audit 5 random Residents to ensure medication availability weekly x 4 weeks and then monthly x 2 months. " Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.	

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N 093	Continued From page 8 An interview was conducted with the Unit Manager (UM) on at 11:45 AM. The UM stated it was the nurse's responsibility to reorder medications from pharmacy when a resident gets down to a 5 day supply left. Class III	N 093		
N 111 SS=F	59A-4.122(2), FAC Physical Environment - Specifics The licensee must provide: (a) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; (b) Clean bed and bath linens that are in good condition; (c) Furniture, such as a bed-side cabinet, drawer space; (d) Adequate and comfortable lighting levels in all areas; (e) Comfortable and safe room temperature levels; in accordance with 42 CFR, Section 483.15(h)(6), which is effective , and, is incorporated by reference and available at http://www.gpo.gov/fdsys/pkg/CFR-2014-title42-vol5/xml/CFR-2014-title42-vol5-sec483-15.xml; and, (f) The maintenance of comfortable sound levels. Individual radios, TVs and other such transmitters belonging to the resident will be tuned to stations of the resident's choice. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to have an effective pest	N 111	Preparation and/or execution of this plan does not constitute admission or	

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control program.

The findings included:

1). During the Resident Council meeting, on at 2:30 PM, Resident #70 in stated that he had seen roaches in his bathroom. During a tour of the resident's room, on at 5:11 PM, this surveyor observed one roach on the floor under the sink in the resident's restroom and live roaches, in all stages of life and too numerous to count, in the resident's room under and behind a piece of furniture used for keeping resident's personal clothing and belongings.

On at 5:40 PM, the Director of Maintenance was made aware of the roaches by way of this surveyor showing him the roaches in Resident #70's room and restroom. During an interview, the Director of Maintenance stated that he was aware of the problem and further stated, "this is one of the four rooms that have been brought to our attention. I will call pest control and have them come out as soon as possible.

2). During an observation of the Restorative Dining Room, on at 7:11 AM, this surveyor observed 4 roaches and 8 live mature and , roaches in the restorative dining room and one roach on the floor in the hall just outside of the entrance to the Restorative Dining Room.

During an interview with the Dietary Manager, on at 7:23 AM, she stated that there had been no reports of roaches from staff or residents. She further stated that (pest control) comes every two weeks, including during the previous weekend, to treat the kitchen and dining

agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole purpose of compliance with State and Federal Regulations.

N111 Physical Environment
1) What corrective action will be accomplished for those residents found to have been affected by this practice?
Pest control was immediately contacted, upon arrival the Pest Control , serviced the identified resident rooms, as well as the dining and nourishment rooms.
2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken.
On ED/designee conducted pest control audit of the Facility. No additional pests were identified.
3) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur?
On , ECO Lab completed in-service with Facility Department Heads regarding immediately reporting the identification of pests in the Facility, give specific details about the location of the sighting, and logging the sighting in the Pest Control Log Binder located at the Receptionist's Desk. Additionally, Pest Control Log Binders have also been placed at 1st floor Nursing Station, 2nd floor Nursing station, and Seaside Nursing Station on 2nd floor.
4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put

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N 111	Continued From page 10 rooms. During an interview with the Interim Administrator, the Corporate Vice President and the Director of Maintenance, on . . . . . at 7:38 AM, the Interim Administrator stated that they are going to "close the dining room, give it a deep cleaning and pest control should be here around 8:00. We are going to keep it closed at least for breakfast." On . . . . at 11:38 AM during an interview with Service , from (pest control), he stated, "If some one reports that they have seen a pest, they log it into the (pest control company) log book and call the 1800 number and then I have 24 hours to respond. I usually come out the same day or the next morning. I treat and document in the log book. When we have activitiy we treat the room, I follow up with the Maintenance Director. After I treat, I have 24-48 hours to show up/follow up. We are going to treat one unit each week, even if there is no activity. The facility is moving the residents for the time that I am spraying and treating their rooms. The common areas are treated at night when there is nobody around, they know how to prepare for us to come in at night and they know when we are going to come in for the food and beverage areas including both dining rooms and the kitchen. Anything that can be contaminated when we flush (crack and crevice) is covered, we bait, we dust and do residual spray. They (the facility staff) clean up when they come in. It seems to come and go. The problem that I run into is that the residents have to leave the rooms while I am treating the room. I will be tomorrow to follow up because I was here today." During a follow up interview, on . . . . at 11:36 AM, with the Service ., from (pest	N 111	into place? " ED/designee to audit Pest Control Binders weekly x 4 weeks and then monthly x 2 months to ensure compliance with pest control program. " Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.	

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control), he stated, "When there is a room with roaches you will find them in the dresser and the drawers. I ask them to prep the rooms by moving the drawers and items from the furniture. Recently, they haven't been prepping properly by making the room treatable for me to go in and do a thorough treatment. I come out once a month for regular service and whenever they request. The kitchen is treated overnight."

3) In an observation conducted on at 9:15 AM in the main dining room on the second floor, revealed the following: a buffet table/beverage counter was observed in the corner of the dining room. In a closer observation it had 3 drawers that were noted to be with pests/roaches in all stages of life. Another drawer was noted with dirty/debris linens and a kitchen mitten. The second drawer to the right had an egg sandwich in a foil paper with a cup of oatmeal, and a cup of opened sugar. The top part of the counter had spilled liquid which may be coffee, but surveyor was not sure. Staff A and the Certified Dietary manager acknowledged the findings and removed the linen and the food from the counter and draws.

4) In an observation conducted on at 9:25 AM in the first floor's pantry revealed two drawers with pests/roaches in it. Closer observation showed dirt and open jelly packages in the drawers. A tray was noticed on top of the counter that had fruits and packages of crackers in close proximity to the pests. Surveyor pulled the refrigerator to have a closer look behind. There were pests/roaches at all stages of life running on the walls and on the floor behind and under the refrigerator. Staff B and a pest control company staff acknowledged the findings.

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N 111	Continued From page 12 Class III	N 111		
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 observation, interview, and record review, the facility failed to clarify need for ... medication and notify MD and document why medication held for 1 of 5 residents observed for medication administration observation (Resident #60). Based on observation, interviews and record review the facility failed to maintain acceptable parameters of nutritional status, for 1 resident of 5 sampled residents (Resident #65). Based on observation and interview the facility failed to provide a safe environment for 6 residents documented as an elopement risk, one of which is also a smoker. The residents included Resident #10, #26, #47, #53, #66, and #285. The findings included: 1. Resident #60 was admitted to the facility on ... with diagnoses included ... and	N 201	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole purpose of compliance with State and Federal Regulations. N201 Right to Adequate and Appropriate Health Care A) What corrective action will be accomplished for those residents found to have been affected by this practice? Resident #60's Physician was notified and a Medication Error Report completed. Resident #65 Physician was notified and Resident was reassessed by the Dietician; No ... loss was noted and Physician's Order was updated to include Registered Dietician's recommendations.	

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N 201	Continued From page 13 A review of the resident's Medication Administration Record (MAR) revealed Resident #60 received (medication to increase) 2.5 milligrams two times a day at 9:00 AM and 9:00 PM. Further review of the MAR revealed the medication was held 9:00 AM on , , and . There was no documentation as to why the medication was held, or the physician being notified. Further review of Resident #60's MAR revealed the resident had vital signs documented every shift. Resident #60's , ranged from - . There were no parameters to administer or hold the medication. An interview was conducted with the Unit Manager (UM) on at 2:00 PM. The UM verified when a medication is held, the reason should be documented and the physician notified. The UM further stated the physician should have been contacted to inquire if the resident still needed the medication or for parameters to hold the medication. 2. Review of the record revealed Resident #65 was admitted on with diagnoses of , legal , , and . Review of Resident #65's are as following: , , , , and , . Review of the nutrition progress note dated revealed that Resident #65 is readmitted from the hospital after a placement. His is currently receiving 5 cans of feeding formula that is providing: 1500 calories, 75 grams of protein and 1020 milliliters of fluids. Resident	N 201	Upon discovery of need, Staff members were assigned 24/7 to monitor the affected door 1:1 until repairs were completed. B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken. On , DON/designee completed a comprehensive audit of Residents on Medications to ensure the medication was administered complaint with Physician's Orders; and completed an audit of current Residents with to ensure accuracy of feed. On , ED/designee completed a comprehensive audit of Facility egress doors to ensure no other doors were affected. C) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? " By the DON/designee completed Re-education with the Licensed Nursing Staff on the administration of medications compliant with Physician's Orders, as well as, regarding notifying Physician of Registered Dietician's recommendations. " By , the ED/designee completed Re-education with the Maintenance Director and Maintenance Assistants on the components of F689 with emphasis on Guard doors and ensuring safe Facility environment. D) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place?	

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N	Continued From page 14 #65 is at suboptimal nutrition related to current regimen not meeting estimated needs as per dietitian. Estimated nutritional needs are as following: 1675-2010 calories/day, 67-80 grams/protein a day and 1675-2010 millimeter/day of fluids. The dietitian recommended to increase the regimen to 6 cans a day which will provide: 1800 calories/day, 90 grams of protein and 1224 milliliters of water. His Ideal Body is noted at Review of the Dietary Communication Form to the physician dated revealed the dietitian recommendations for 6 cans of 1.2 per day. Further record review of the Medication Administration Record (MAR) for Resident #65 for the month of , showed that he received 5 cans of from to and not the recommended regimen by the dietitian. Further record review of the nutrition progress note dated revealed that there was a recent increase in bolus feeding to 6 cans of per day. Progress note dated showed that Resident #65 had been changed to Isosource 1.5 feeding formula at 65 milliliters times 20 hours and was providing: 1950 calories/day, 88 grams/protein a day, and 988 millimeters of fluids. In an interview on at 3:48 PM with Staff A, she reported that Resident #65 is at high nutritional risk. She confirmed that the regimen needed to be increased to 6 cans a day. When asked by surveyor as to what is the protocol for communicating with the doctor, she stated that they put the recommendation in the chart and it gets picked up by nursing. According to Staff A, nursing calls the doctor with	N 201	" DON/designee will weekly audit 5 random Residents on medications to ensure medications are administered compliant with Physician s Orders, as well as, audit 5 random Residents to ensure accuracy of Feed orders weekly x 4 weeks and then monthly x 2 months. " Maintenance Director/designee to randomly audit guard doors to ensure functionality weekly x 4 weeks and then monthly x 2 months. " Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.	

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the dietitian's recommendations. If the physician did not see the recommendations then the dietitian needs to contact the physician directly.

In an interview on ... at 4:00 PM with Staff B, he reported that the recommendations by the dietitian on ... was never picked up by nursing. When asked as to why the recommendations were never implemented Staff B reported that he didn't know.

Review of the Change Communication Form dated ... by Staff A showed that Resident #65 had a % in 90 days. Staff A is requesting the physician to consider future management, and order lab with next set of labs. Resident #65 is with ( ) of 20.0 which is

3. On ... at 3:30 PM an attempt was made to locate a resident for an interview on the second floor. The Unit Manager suggested that the resident may be outside of the building either on the front or ... patio.
At the front patio there were several residents. Approximately 10 ... from the residents was an open gate that lead to an open door to the stairwell and an inner door. The inner door was unlocked, which allowed for easy access into the facility. A check of the open door from inside the facility revealed it was unlocked and the exit alarm was not active. Further observation revealed written signs that indicated that the exterior door was not to be left opened.
The patio was then visited. An open gate leading to the parking lot was observed. A continued walk around the perimeter was performed, where it was noted that there were no security cameras and there was easy access to

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N 201	Continued From page 16 the street in front of the facility. These observations were reported to the Team Leader and another team member, both of whom made all of the same observations at that time. The Facility Administrator and the ... of Maintenance were notified. The of Maintenance walked the perimeter of the facility with the surveyor and observed the issues described. A test of the ... Guard system was conducted by the Administrator with the ... of Maintenance present. The ... Guard sensor failed to set off an alarm at the door in question. The same ... Guard sensor worked on all other doors. The Administrator and ... of Maintenance both acknowledged this was a serious safety issue and immediately started to work on correcting the problem. Photographic evidence obtained. Class III	N 201		
N 209 SS=D	400.022(1)(u), FS Right to Bed Hold Policy The right to be informed of the bed reservation policy for a hospitalization. The nursing home shall inform a private-pay resident and his or her responsible party that his or her bed will be reserved for any single hospitalization for a period up to 30 days provided the nursing home receives reimbursement. Any resident who is a recipient of assistance under Title XIX of the Social Security Act, or the resident's designee or legal representative, shall be informed by the licensee that his or her bed will be reserved for any single hospitalization for the length of time for which Title XIX reimbursement is available, up to 15 days; but that the bed will not be reserved if it	N 209		

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N 209	Continued From page 17 is medically determined by the agency that the resident will not need it or will not be able to return to the nursing home, or if the agency determines that the nursing home's occupancy rate ensures the availability of a bed for the resident. Notice shall be provided within 24 hours of the hospitalization. This Statute or Rule is not met as evidenced by: Based on interviews and record review the facility failed to provide the bed hold policy notice for hospital discharge for 1 of 4 sampled residents (Residents #4). The findings included: Review of the record revealed that Resident #4 was admitted to facility on ; and he was discharged to the hospital on . His diagnoses included acute , , failure and . Review of the Minimum Data Set (MDS) dated showed that Resident #4 is with s ( ) score of 03 indicating that he has severe . Section A of the MDS showed that he had an unplanned discharge to an acute hospital. Section Q of the MDS showed that Resident #4 participates in his assessments. In an interview conducted on at 1:35 PM with Staff B, Unit Manager, he reported that when residents are discharged to the hospital the facility provides them with the bed hold policy and the nursing home transfer and discharge notice. When asked if Resident #4 received the bed hold policy, Staff B reported that he was not in the facility when the Resident was discharged, and he is not sure if he received the correct paperwork. Surveyor asked if he had the bed	N 209	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole purpose of compliance with State and Federal Regulations. N209 - Right to Bed Hold Policy 1) What corrective action will be accomplished for those residents found to have been affected by this practice? " Resident # 4 no longer resides in this Facility. 2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken. " On , Executive Director/designee completed a comprehensive audit of discharges to the hospital in the last 30 days. For residents who remained in the hospital, the facility sent a Bed Hold Notice via certified mail to the resident and/or responsible party ensuring they were aware of the bed hold policy. 3) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur?	

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	95024	A. BUILDING: ______ B. WING ______	01/10/2019

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N 209	Continued From page 18 hold/nursing home discharge notice for Resident #4 and he replied no. Staff B stated that it is the responsibility of the social worker to provide the bed hold policy and the nursing home discharge notice. In an interview conducted on . . . . . at 1:48 PM with the social worker, she reported that when residents are discharged to the hospital it is the responsibility of nursing to provide all the paperwork. She further stated that if the residents are discharged to the community then she provides all the discharge documentation and notices. In an interview conducted on at 2:20 PM with the Director of Nursing, she stated that if residents are discharged to the hospital it is the responsibility of nursing to provide the bed hold policy. She further stated that an in-service was provided to nursing regarding discharge policies and notices. Class III	N 209	" By . . . . , the Director of Nursing or designee completed Re-education with the facility Licensed nursing staff on the components of F625 with emphasis on ensuring the facility completes a Bed Hold Notification Form at time of discharge or as soon as possible after discharge to the resident and/or their responsible party. " Newly hired Licensed Nursing Staff will be educated to the components of F625 with specifications to the above-mentioned areas. 4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place? " Director of Nursing/designee to randomly audit 5 resident records of residents transferred to the hospital to ensure that a bed hold was provided to the resident/responsible party weekly x 4 weeks and then monthly x 2 months. " Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.	
N 903 SS=D	400.147(1)(b), FS Risk Mgmt & Q A Committee A risk management and quality assurance committee consisting of the facility risk manager, the administrator, the director of nursing, the medical director and at least three other members of the facility staff. The risk management and quality assurance committee shall meet at least monthly.	N 903		

Agency for Health Care Administration

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N 903	Continued From page 19 This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to develop appropriate plans of actions to correct identified deficiencies related to pest control. The findings included: The facility was cited for not having an effective pest control program in the last standard survey dated . The facility was found to have deficient practice during the standard recertification survey related to not having an effective pest control program. An interview was conducted with the facility plant operations manager on at 1:40 PM. The plant manager stated they had implemented a pest control log where sightings of roaches were logged in. The pest control company comes monthly and as needed. With each sighting, the pest control company was to be called out to the facility. A review of the pest control log revealed the pest control company had come to the facility five times in . The Plant Operation Manager further stated they would now have the pest control company come out to the facility weekly, and rearrange the residents so a deep clean and treatment for roaches could be done. An interview was conducted with the Interim Nursing Home Administrator (NHA) and Regional Vice President of Operations on at 1:40 PM. The NHA stated the facility was going through a transitional stage.	N 903	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sole purpose of compliance with State and Federal Regulations. N903 Risk Mgmt & QA Committee 1) What corrective action will be accomplished for those residents found to have been affected by this practice? Pest control was immediately contacted, upon arrival their , serviced the identified resident rooms, as well as dining and nourishment rooms. 2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken. On an Ad Hoc QAA/QAPI Committee Meeting was held to discuss Survey results of Annual Survey with enhanced emphasis placed upon the implementation and monitoring of corrective action plans. 3) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? By , the RVPO/designee completed education with the Executive Director and QAA Committee regarding implementation and monitoring of Quality Assurance and Performance Improvement Activities. 4) How will the corrective actions be monitored to ensure the practice will not	

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N 903	Continued From page 20 Class III	N 903	reoccur, what quality measures will be put into place? " ED/designee to review, during monthly scheduled QAA Committee Meetings, results of corrective action plans in place. " Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.	