DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03052/2019 CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

ENTERS FOR MEDICARE & MEDICAID SERVICES O				
TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105762	B. WING		02/07/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS CITY STATE ZIP CODE	

11375 PROSPERITY FARMS ROAD HEARTLAND HEALTH CARE CENTER PROSPERITY OAKS PALM BEACH GARDENS, FL 33410 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 An unannounced Recertification and Complaint survey CCR # 2019000002 and CCR # 2019001166 was conducted on at Heartland Health Care Center Prosperity Oaks. For the Complaint surveys: CCR # 2019000002- The allegations were not substantiated. CCR # 2019001166- The allegations were not substantiated The facility is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. F 623 Notice Requirements Before Transfer/Discharge F 623 SS=E CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

/2019

TITLE

Any deficiency statement ending with an asterisk (1) 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 disclossable 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 disclossable 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 participates.

Electronically Signed

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PRINTED: 03/05/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF REALTH AND HOWAN SERVICES					
ENTERS FOR MEDICARE & MEDICAID SERVICES Q					
ATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	105762	B. WING		02/07/2019	
VAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			11375 PROSPERITY FARMS ROAD		

		103702	D. WING			02/	07/2019
NAME OF P	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
			- 1	١,	1375 PROSPERITY FARMS ROAD		
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F 623	§483.15(c)(4) Timing (1) Except as specified (c)(8) of this section, tdischarge required un made by the facility al resident is transferred (ii) Notice must be me before transfer or disc. (A) The safety of individent is section; (B) The health of individent in the section; (C) The resident's health or an order to the section; (C) The resident's health or an order paragraph (c)(7) (D) An immediate trar required by the reside under paragraph (c)(7) (E) A resident has not days.	of the notice. In paragraphs (c)(4)(iii) and the notice of transfer or detr this section must be teast 30 days before the tor discharged, the section paragraph (c)(1)(i)(C) of paragraph (c)(1)(i)(C) of viduals in the facility would paragraph (c)(1)(i)(D) of alth improves sufficiently to the transfer or discharge, i)(i)(ii) of the section;	F	623			
	notice specified in par must include the follor (i) The reason for trai (ii) The leffective date (iii) The location to wit ransferred or dischar () A statement of the including the name, a and telephone numbe receives such reques to obtain an appeal for completing the form a hearing request;	ragraph (c)(3) of this section wing: nster or discharge; of transfer or discharge; iich the resident is ged; readent's appeal rights, ddress (mailing and email), or of the entity which is, and information on how					

Facility ID: 95038

PRINTED: 03/05/2019

		ID HUMAN SERVICES					APPROVED
		MEDICAID SERVICES					0. 0938-0391
STATEMENT OF DEF AND PLAN OF CORF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105762	B. WING			02/	07/2019
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				l	11375 PROSPERITY FARMS ROAD		
HEARTLAND H	EALTH CARE CEN	TER PROSPERITY OAKS			PALM BEACH GARDENS, FL 33410		
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tele Lon (vi) and and tele the tele the code (vii) and and cod (viii) and age adva esta for I fo	g-Term Care Omt For nursing facility. the mailin shone number of protection and ad the Bill of Rights Act fied at 42 U.S.C. For nursing facility or related ill address and tel grade and the short of	the Office of the State underman, residents with intellectual or related g and email address and the agency responsible for vocacy of individuals with established under Part Assistance of 2000 (Pub. L. 108-402, 15001 et seq.); and y residents with a mental the mailing and ephone number of the or the protection and lis with a mental Protection and Advocacy units Act.	F	62:			

Based on record review and interview, the facility

Facility ID: 95038

Without admitting or conceding either the

		ID HUMAN SERVICES MEDICAID SERVICES				NTED: 03/05/2019 FORM APPROVED B NO: 0938-0391
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		DATE SURVEY COMPLETED
		105762	B. WING _			02/07/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
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F 623	failed to ensure that the resident's representation with all the required control initiated transfer or discisional feed of the failed of the following: atte, multiple disruption of rinder or country of the failed of the fa	he resident and the view was notified in writing omponents, before a facility scharge for 4 of 4 sampled #27, #29, # 115 and #267) zation. coriginally admitted to the he was discharged to the and readmitted to the facility agnosis that includes some of unspecified of with stable g, subsequent encounter aling, and #27's nurses progress note to PM revealed that the stant (CNA) notified the hable to assist. Resident # to her wheelethair, the	F€	existence or scope or deficiencies, Heartland Prosperity Oaks submit correction in order to by with the regulations. F623 Resident #29 has since to the facility. Revenue and the facility. Revenue and the facility Revenue and the facility. Other residents within the facility. Other residents within the facult hospital dischard, documentation provide and/or representative or rights, including name, telephone number of the receives such request, how to obtain an appearance of the stephone number of the submitting the appeal and the name, address telephone number of the State Long Term Care required. An audit tool of the side of the submitting the appeal of the state Long Term Care required. An audit tool with within the side of the side of the state Long Term Care required. An audit tool with within the side of t	I Health Care its this this plan of the in compliance of the incompliance of the incom	

assisted ... into bed by two staff, the medical doctor was notified. Resident # 27 left the facility via 911, to the emergency room (ER) to be further evaluated. The responsible party was made aware, a bed hold policy, and a copy of) was sent.

A review of Resident #27's Physician Order dated revealed an order to send Resident # 27 to the ER Eurther review of Resident # 27's record revealed an "Acute Care Transfer" form

included information but not limited to Facility ID: 95038

the resident discharged to acute care

Measurements or systemic changes: The appropriate staff was in-serviced on

the regulation of Notice Requirement

Before Transfers/Discharge related to

acute care placement. The in-service

and notice sent.

setting including name, date, placement

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/05/2019 CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
AND DE AN OF COORDECTION SOME STORY AND ASSESSMENT ASSESSMENT AND ASSESSMENT ASSESSMENT ASSESSMENT AND ASSESSMENT AS) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED		
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HEARTLA	ND HEALTH CARE CEN	TER PROSPERITY OAKS		11375 PROSPERITY PALM BEACH GAR			
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F 623	dated upon Care Transfer form re a statement of the res	further review of the Acute evealed that the form lacked sident's appeal rights, iddress (mailing and email),	F6	documentation residents and/ rights, notifica needed. Monit	n, communication with for representative, appea tion with MD as deemed toring of compliance will by the Social Service		

and email) and telephone number of the Office of the State Long-Term Care Ombudsman as required.

In an interview completed on ... at 9:20 AM with the Social Services Director she acknowledged the findings, and further stated that they have now formulated a new form that captures all the required elements that need to be provided to the resident and the resident's representative.

receives such requests; and information on how

hearing request; and the name, address (mailing

to obtain an appeal form and assistance in completing the form and submitting the appeal

b) Resident #29 was originally admitted to the facility on and discharged to the hospital on readmitted on with a diagnosis that includes some of the following: tension-type unspecified and chondrocostal junction

revealed Resident # 29 was lying on her right side exhibiting labored breathing and complaining of left arm, radiating to the complaining of left arm, radiating to the same and order was obtained for which was administered twice. The resident stated she had no relief of the , 911 was called and the resident was transferred to the hospital. A beh lold policy was sent with the

A review of Resident #29's progress note, dated

documentation, communication with residents and/or representative, appeal rights, notification with MD as deemed needed. Monitoring of compliance will be demonstrated by the Social Service Director through the weekly quality assurance meeting with an audit tracking tool ensuring compliance with individual acute transfers/discharge of each resident.

Monitoring to ensure the deficient practice does not reoccur:
The Social Service Director will monitor this deficient practice in the quality assurance meeting each month for the next 3 months alleging compliance. Findings will be reported in the monthly quality assurance committee meeting and then randomly thereafter.

PRINTED: 03/05/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES

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ENTERS FOR MEDICARE & MEDICAID SERVICES C						
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
	105762	B. WING		02/07/2019		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
		- 1	11375 PROSPERITY FARMS ROAD			
HEARTLAND HEALTH CARE CENTER PROSPERITY OAKS			PALM BEACH GARDENS, FL 33410			
(X4) ID SUMMARY ST	ATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRECTION	(X5)		

		105762	B. WING _			02/07/2019	
	ROVIDER OR SUPPLIER	ER PROSPERITY OAKS		11	TREET ADDRESS, CITY, STATE, ZIP CODE 1375 PROSPERITY FARMS ROAD ALM BEACH GARDENS, FL 33410		
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F 623	resident. The Medical resident's son were ne Further review of Res an "Acute Care Trans revealed that the form resident's appeal right address (mailing and the entity which receive information on how to assistance in complet the appeal hearing readdress (mailing and address (mailing and and	Doctor (MD) and the biffled. Ident # 29's record revealed ferr form, dated	F	523			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/05/2019

DEFAILT	MENT OF HEALTH AN	ID HOMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		105762	B. WING	_		02/	07/2019
NAME OF P	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
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HEARTLA	NO REALIN CARE CEN	TER PROSPERITY OARS		F	PALM BEACH GARDENS, FL 33410		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623		eted on at 9:20 AM ces Director she	L.	623			
	on after beir on for a cha history included: Acut Failure,	is readmitted to the facility ing transferred to the hospital inge in condition. Medical te Hypoxemic , and ft , and right ankle.					
	at 11:51 reve elevated temperature Fahrenheit axillary, re wet and clammy, labo	edness to skin ored breathing; 24 and us 89%. The emergency is notified and the resident					
		n and family					
	on . Upon fur Care Transfer form re a statement of the res including the name, a and telephone numbe receives such reques to obtain an appeal for	address (mailing and email), er of the entity which sts; and information on how					

hearing request; and the name, address (mailing and email) and telephone number of the Office of

Facility ID: 95038

PRINTED: 03/05/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED ST ۵ħ

CENTERS FOR MEDICARE & MEDICAID SERVICES C					
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
	105762	B. WING	00/07/0040		

02/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

11375 PROSPERITY FARMS ROAD HEARTLAND HEALTH CARE CENTER PROSPERITY OAKS PALM BEACH GARDENS, FL 33410 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY) F 623 Continued From page 7 F 623 the State Long-Term Care Ombudsman as required. In an interview conducted on at 2:55 PM with the Corporate Nurse, Social Service Director and Acting Director of Nursing (DON), they acknowledged the findings. In a subsequent interview conducted on at 9:20 AM with the Social Services Director, she stated that they have now formulated a new form that captures all the required elements that need to be provided to the resident and the resident's representative.

Facility ID: 95038

(X6) DATE

Agency fr	or Health Care Adminis	tration				0: 03/05/2019 1 APPROVE
STATEMENT	FOR CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPLI	
		95038	B. WING		02/0	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
HEADTIA	ND HEALTH CARE CEN	TER PROPERTY (11375 PI	ROSPERITY FAR	MS ROAD		
IILAK ILA	MD TEACHT CARE CEN	PALM B	EACH GARDENS	, FL 33410		
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N 000	INITIAL COMMENTS		N 000			
	survey CCR# CCR # #2019001166 was 2 #201900160 was 2 #2019000002- #2019000002- #2019000002- #2019001166- #2019001166- #2019001166- #2019001166- #2019001166- #2019001166- #2019001166- #2019001166- #2019001166- #2019001166-	Health Care Center				
N 506 SS=E	The notice required b writing and must cont by state and federal la applicable to Medicai agency shall develop used by all facilities it purposes of notifying transfer. Such docum for a resident to reque ombudsman council	harge/ Transfer Notice y subsection (7) must be in ain all information required aw, rules, or regulations of or Medicare cases. The a standard document to be censed under this part for residents of a discharge or ent must include a meens st the local long-term care o review the notice and bout or assistance with	N 506			

AHCA Form 3020-0001

action. Further, the form must state the effective date of the discharge or transfer and the location LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

initiating a fair hearing with the department's Office of Appeals Hearings. In addition to any other pertinent information included, the form shall specify the reason allowed under federal or state law that the resident is being discharged or transferred, with an explanation to support this

Electronically Signed /19

TITLE

STATE FORM BOY611 if continuation sheet 1 of 6

Agency f	or Health Care Adminis	stration				: 03/05/2019 I APPROVED
STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		95038	B. WING		02/0	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE		
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N 506	transferred. The form resident's appeal righ filing an appeal, inclu local ombudsman con discharge or transfer. be placed in the residency must be transm guardian or represen ombudsman council signature by the resident of the resident of the resident's representative and the resident's representative and the resident's representative and the resident's representative and the resident (Residents reviewed for hospitalism on the residents (Residents reviewed for hospitalism on the residents (Residents reviewed for hospitalism on the residents (Residents reviewed for hospitalism on the following: site, multiple disruption of first fill residents (Residents reviewed for hospitalism) and the following: site, multiple disruption of first fill residents (Residents reviewed for hospitalism) and the following: site, multiple disruption of first fill residents (Residents reviewed for hospitalism) and the following: site, multiple disruption of first fill residents (Residents reviewed for hospitalism) and fill residents (Residents reviewed for hospitalism).	is being discharged or must clearly describe the ts and the procedures for clining the right to request the uncil review the notice of A copy of the notice must earl's clinical record, and a titted to the resident's legal adive and to the local within 5 business days after within 5 business days after lent or resident designee. Is not met as evidenced by: we and interview, the facility he resident and the five was notified in writing omponents, before a facility scharge for 4 of 4 sampled #27, #29, # 115 and #267) zation. It conginally admitted to the he was discharged to the and readmitted to the facility agnosis that includes some of unspecified	N 506	Without admitting or conceding either existence or scope or severity of the deficiencies, Heartland Health Care Prosperity Oaks submits this plan of correction in order to be in complianc with the regulations. N506 Resident #29 has since been readmit to the facility. Resident #115 has since beer readmitted to the facility. Reside #267 has since beer readmitted the facility. Other residents having the potential to affected: Residents within the facility requiring acute hospital discharge have received occumentation provided to the reside documentation provided to the reside documentation provided to the reside	e ted s s n not to	
	A review of Resident	#27's nurses progress note		and/or representative of their appeal		

AHCA Form 3020-0001

27

... at 1:40 PM revealed that the

from the toilet to her wheelchair, the

Certified Nursing Assistant (CNA) notified the

nurse that she was unable to assist Resident #

STATE FORM 699 BOY611 H continuation sheet 2 of 6

rights, including name, address, and

telephone number of the entity which

how to obtain an appeal form and

receives such request, and information on

PRINTED: 03/05/2019 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B MING 95038 02/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11375 PROSPERITY FARMS ROAD HEARTLAND HEALTH CARE CENTER PROSPERITY (PALM BEACH GARDENS, FL 33410 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 506 Continued From page 2 N SOS nurse evaluated the resident, and noted submitting the appeal hearing request, generalized and incoherent speech. and the name, address, email, and Resident #27 wasn't able to lift her left arm, no telephone number of the Office of the range of motion in her arm. Resident #27 was State Long Term Care Ombudsman as assisted ... into bed by two staff, the medical required. An audit tool was used to track doctor was notified. Resident # 27 left the facility the resident discharged to acute care via 911, to the emergency room (ER) to be further setting including name, date, placement evaluated. The responsible party was made and notice sent. aware, a bed hold policy, and a copy of) was sent. Measurements or systemic changes: The appropriate staff was in-serviced on A review of Resident #27's Physician Order dated the regulation of Notice Requirement revealed an order to send. Resident # Before Transfers/Discharge related to 27 to the ER. Further review of Resident # 27's acute care placement. The in-service record revealed an "Acute Care Transfer" form included information but not limited to dated , upon further review of the Acute documentation, communication with Care Transfer form revealed that the form lacked residents and/or representative, appeal a statement of the resident's appeal rights. rights, notification with MD as deemed including the name, address (mailing and email). needed. Monitoring of compliance will be and telephone number of the entity which demonstrated by the Social Service receives such requests; and information on how Director through the weekly quality to obtain an appeal form and assistance in assurance meeting with an audit tracking completing the form and submitting the appeal tool ensuring compliance with individual hearing request; and the name, address (mailing acute transfers/discharge of each and email) and telephone number of the Office of resident.

required.

representative.

facility on

on

the State Long-Term Care Ombudsman as

acknowledged the findings, and further stated

that they have now formulated a new form that

b) Resident #29 was originally admitted to the

diagnosis that includes some of the following:

; readmitted on

and discharged to the hospital

with a

provided to the resident and the resident's

captures all the required elements that need to be

with the Social Services Director she

In an interview completed on

at 9:20 AM

Monitoring to ensure the deficient practice

The Social Service Director will monitor

assurance meeting each month for the

Findings will be reported in the monthly

quality assurance committee meeting and then randomly thereafter.

this deficient practice in the quality

next 3 months alleging compliance.

does not reoccur.

PRINTED: 03/05/2019 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 95038 02/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11375 PROSPERITY FARMS ROAD HEARTLAND HEALTH CARE CENTER PROSPERITY (PALM BEACH GARDENS, FL 33410 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 506 Continued From page 3 N SOS tension-type, unspecified , 🛫 , and chondrocostal junction A review of Resident #29's progress note, dated revealed Resident # 29 was lying on her right side exhibiting labored breathing and complaining of left arm . radiating to the She was administered . , . . at 2 liters and an order was obtained for which was administered twice. The resident stated she had no relief of the . . 911 was called and the resident was transferred to the hospital. A bed hold policy was sent with the resident. The Medical Doctor (MD) and the resident's son were notified. Further review of Resident # 29's record revealed revealed that the form lacked; a statement of the resident's appeal rights; including the name, address (mailing and email); telephone number of the entity which receives such requests; information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request and the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care

Ombudsman as required.

c) Review of the medical record for Resident #115, revealed an admission date of with diagnoses including: ... and A review of the Nurses progress note dated documented that the physician called and ordered that the resident he sent to the hospital emergency room due to an abnormal . Copy of the bedhold policy was sent, the

STATE FORM caso BOY611 If continuation sheet 4 of 6

						: 03/05/2019 I APPROVEE
Agency fo	or Health Care Adminis	tration				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		95038	B. WING		02/07/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
	UD UEALTH OADE OFF	11375 PR	OSPERITY FAR	MS ROAD		
HEARTLAND HEALTH CARE CENTER PROSPERITY (PALM BEACH GARDENS, FL 33410						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (X5) EACH CORRECTIVE ACTION SHOULD BE COSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE DATE	
N 506	Continued From page 4		N 506			
	resident's son was notified.					
	lacked a statement of including the name, a and telephone number receives such reques obtain an appeal for completing the form a hearing request; the email) and telephone	I revealed that the form if the resident's appeal rights, ddress (malling and email), or of the entity which is; information on how to and assistance in ind submitting the appeal name, address (mailing and number of the Office of the 9 Ombudsman as required, eted on at 9:20 AM bes Director she				
	on after beir on for a cha history included: Acut Failure, to lef A review of the Nurse at 11:51 reve	t and right ankle. s' progress notes dated aled that the resident had an				
	elevated temperature Fahrenheit axillary, re	of 103.5 degrees dness to , , skin				

notification was mailed out. AHCA Form 3020-0001

saturation was 89%. The emergency medical response was notified and the resident was transferred to the hospital.

the Director of Social Services acknowledged that the resident Ombudsman Discharge Notification was faxed to the Ombudsman office on and family

PRINTED: 03/05/2019 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 95038 02/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11375 PROSPERITY FARMS ROAD HEARTLAND HEALTH CARE CENTER PROSPERITY (PALM BEACH GARDENS, FL 33410 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 506 Continued From page 5 N SOS The "Acute Care Transfer" form was completed .. Upon further review of the Acute on . . . Care Transfer form revealed that the form lacked a statement of the resident's appeal rights including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; and the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman as required. In an interview conducted on at 2:55 PM with the Corporate Nurse. Social Service Director and Acting Director of Nursing (DON), they acknowledged the findings. In a subsequent interview conducted on at 9:20 AM with the Social Services Director, she stated that they have now formulated a new form that captures all the required elements that need to be provided to the resident and the resident's representative. Class III