STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964446	08/16/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Isles Of Vero Beach	1700 Waterford Drive Vero Beach, FL 32966	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0000 - - Initial Comments
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0057 - 58a-5.0185(8) Fac - Medication - Over The Counter (OTC) Products S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced Assisted Living Facility relicensure survey was conducted on and Isles of Vero Beach, had licensure deficiencies found at the time of the visit.

The relicensure survey was conducted in conjunction with complaint survey CCR#2013001700.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC

Based on record review and staff interview, the facility failed have a fully completed Health Assessment (Form 1823) for 2 out of 2 sampled resident records reviewed (Resident #2 and #3).

The findings include:

During record review on for Resident #3 and Resident #4, it was noted Section 2-B of both of the Residents' Health Assessments (Form 1823) were not completed. There was no indication for either resident as to whether the resident needed "Assistance with Self-Administration of Medications" or needed "Medication Administration".

Class III

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on resident record review and staff interview, the facility failed to require a face-to face medical examination by a licensed health care provider after a significant weight loss was noted, for 1 of 2 residents whose records were reviewed (Resident #2).

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The findings include:

During resident record review for Resident #2 on , the weight recorded for 2013 is documented as 235 the weight recorded for 2013 is 207, and the weight recorded for 2013 is 221. The weight loss from 2013 to 2013 is 28 which is a significant weight loss within one month. No documentation is contained in the resident's record as to a reason for this weight loss, nor is there any documentation of a face-to-face medication examination by the resident's physician, or an updated Health Assessment (Form 1823) due to the significant change.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC

Based on observation, record review, and interviews, the facility failed to make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication are filled or refilled in a timely manner, for 3 out of 3 sampled residents (Resident #2, #3, and #10).

Based on observation and staff interview, the facility failed to provide residents' their medication within 1 hour of the prescribed time, for 2 out of 2 sampled residents whose medication assistance was observed (Resident #2 and #11).

The findings include:

1) On at 10:05 AM , during observation of medication distribution to Resident #2, it was noted that the Resident's Metroprolol and were not available for the Resident to take. When Med Tech #1 was questioned as to why the medications were unavailable, she stated the Resident's daughter had not picked up the medications from the pharmacy. "I have called the daughter a few times, and she says she will pick them up, but she does not." When asked how long Resident #2 has been without these medications, Med Tech #1 stated, "It has been 5 days."

During interview with the Nurse on at 3:32 PM, she stated, "Three nights ago, someone from day shift talked with the Resident's daughter, and the daughter requested 2 weeks worth of medications to be ordered because the daughter was going on vacation. The Pharmacy filled the meds, and they have been sitting at the Pharmacy waiting for pick-up. [Med Tech #1] spoke with the daughter yesterday and offered to pick up the meds for her, but the daughter said she would pick them up and bring them in today The medications were not picked up. The daughter was called again and the daughter once again said she would pick the pills up tonight and bring tomorrow The family will not pay for emergency meds ordered."

The Nurse was asked if anyone notified the doctor regarding the Resident's missing doses of these medications. The nurse stated she had not.

On , Review of the MOR for Resident #2 revealed Resident had not been given the Physician Ordered

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or for 6 days

It was also noted that from the Resident went without his while waiting on both the doctor's orders and the prescription to be filled.

2) On Review of the 2013 MOR for Resident #3 revealed on 6/4, 6/7, 6/8, and Resident #3 did not receive the prescribed Hydrochlorot due to awaiting arrival of the medication.

On Resident #3 did not receive the prescribed due to awaiting arrival of the medication.

Review of the 2013 MOR for Resident #3 revealed was not given on and Cyanocobalama not given on and Famotide was not given on due to awaiting arrival of the medications.

3) During interview with Resident #10 on at 4:46 PM, she mentioned she had run out of eye drops a couple of times. Resident #10's private caretaker confirmed that there had been times when the Resident did not have her eyedrops due to prescription not being refilled in a timely manner.

On at 12:55 PM, Resident #10's daughter stated, "My mother is not getting her pills in a timely manner. She also is supposed to get two different eyedrops, one of the eyedrops 2 times a day, and the other at night. At least twice a month she is running out of medications. She has and the eye drops help to stall the progression."

4) On at 9:42 AM, during medication observation, it was noted that 8:00 AM medications were being given at 9:45 AM.
Interview with Employee C was conducted at 10:00 AM on She replied in response to being asked why the medications were being passed 2 hours after MOR documents meds are supposed to be given: "We have to stop passing meds to go to the Dining help assist Residents. We resume meds after breakfast."
Interview with the DON on at 5:30, revealed it is the policy of the facility, the owner of the ALF, to utilize the CNAs/Med Techs to assist in the dining meal times.

Class III

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0057-Medication - Over The Counter (OTC) Products 58A-5.0185(8) FAC

Based on observation and staff interview, the facility failed to label Over The Counter (OTC) products with the resident's name, for 2 out of 2 sampled residents observed during Medication Assistance (Resident #2 and #11).

The findings include:

During medication assistance observation on beginning at 9:46 AM, the OTC medication bottles for Resident #2 and Resident #11 were not labeled with the residents' names.
On at 10:10 AM, Med Tech #1 was asked about the labeling of the OTC bottles, and she acknowledged that the bottles should be labeled with the Residents' names.

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on record review and interview, the facility failed to have newly hired staff provide a statement from a health care provider that the employee does not have any signs or symptoms of a communicable , for 1 out of 3 direct care staff members reviewed (Employee C).

The findings include:

On the employee record for Employee C, whose date of hire is was reviewed. A statement from a health care provider declaring the employee is free from signs or symptoms of a communicable was not found within the employee's file.

During interview on at 10:30 AM, Employee C, stated she had turned in the statement declaring her free from any communicable to the facility when she had turned in her test results. She did not know why the statement was not in her record. The DON, who was present during this interview, also stated she could not locate the physician's statement. The opportunity was given to the Employee and to the DON to produce the missing documentation prior to the survey's completion. The Physician's statement declaring Employee C free from communicable was not provided at the time of exit.

Class

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC

Based on observation and staff interview, the facility failed to provide a safe environment free from potential hazards.

The findings include:

At 10:05 AM, a brief observational tour was conducted of the small Assisted Living Dining In a small closet located across from the steam table, several bottles of cleaning solution was observed being stored on the bottom shelf of a shelving unit that also contained clean dishes, silverware, and individually packaged saltine

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crackers. This closet area had no door, so the contents of the closet were easily accessible to anyone.

At 10:10 AM, the DON was shown the closet area and the location of the cleaning supplies. The DON stated she would notify the Chef and have the cleaning supplies removed.

Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06

Based on record review and interview, the facility failed to obtain a Level II Background Screening, for 1 out of 5 employees reviewed (Employee D).

The findings include:

On during employee record review for Employee D, whose date of hire is , there was no documentation found to show a Level II Background Screening had been completed.

A search of the AHCA Background Screening Database was performed on to verify the eligibility status of Employee D. The results revealed "New Background Screening required." On at 1:00 PM, the DON was notified of the missing Level II Background Screening for Employee D. She acknowledged the employee had not had a Level II Background Screening done and needed to be rescreened.

Unclassified

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Isles Of Vero Beach
1700 Waterford Drive
Vero Beach, FL 32966

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2013 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **2013** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

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