STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953321	09/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barrington Terrace At Boynton Beach	**1425 S. Congress Boynton Beach, FL 33426**

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 - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced biennial relicensure visit was conducted on . . . . . - . . . . . Barrington Terrace at Boynton Beach had the following licensure deficiencies identified at the time of this visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on record review and interview, the facility failed to ensure complete and accurate AHCA Form 1823's (medical examinations) were obtained for 4 of 12 sampled Residents (#21, 27, 31 and 34).

The findings include:

1. Medications systems review was conducted . . . beginning at 8:43 AM. The following residents were assisted with self-administration of medications by an unlicensed staff member (Employee G). The following concerns were revealed:

a. Resident #21's medical examination dated . . . . . documented the resident required medication management (by a licensed nurse) on Page 1, and the resident could receive assistance with self-administration of medications (by unlicensed staff) on Page 4. In an interview conducted at 11:50 AM, the facility's Resident Care Director (RCD) stated Page 1 of the medical examination was incorrect.

b. Resident #27's record contained two medical examination forms. One dated . . . . . documented she required administration of medications by a licensed nurse. Another medical examination form identified by the RCD as the most recent was not signed or dated by a health care provider (HCP) and disclosed the resident could receive assistance with self-administration of medications (by unlicensed staff). In an interview conducted at 12:38 PM, the facility's RCD stated the medical examination was incorrect.

c. Resident #31's medical examination from dated . . . . . documented she required medication administration (by a licensed nurse). In an interview conducted at 12:38 PM, the facility's RCD stated Page 1 of the medical examination was incorrect.

2. Review of Resident #34's medical examination form dated . . . . . (1823) documented she required assistance with taking her medications, but both "Needs assistance with self-administration of medications" (by unlicensed staff) and "Needs medication administration" (by a licensed nurse) were circled. In an interview conducted at 12:45 PM, the facility's RCD stated the medical examination was incorrect.

Class III

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0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observations, interviews and record review, the facility failed to safely store a resident's (breathing treatment) unit for 1 of 12 sampled resident's (#21); allowed a private duty aide to remove a resident's medication patch for 1 of 12 sampled resident's (#27); failed to ensure pill crushers were clean for 2 of 3 units observed; and failed to post advocacy contact information or provide required telephone access in their secured memory care unit.

The findings include:

1) Medications systems review was conducted beginning at 8:43 AM. The following concerns were revealed:

a. On at 10:10 AM, Employee I, a licensed practical nurse (LPN) was observed in the second floor hallway in an area located near the wellness center, elevator and a television , assisting Resident #21 with a breathing treatment using a unit. The unit was placed on a buffet-type glass-topped table. Five residents were present in the television , three residents were present outside the wellness center.

On at 3:58 PM, the unit was observed stored on the table, no staff was present at the time.

On at 8:51 AM, with the facility's Resident Care Director (RCD) present, the unit was observed still stored on the table. The RCD stated Resident #21 is scared to receive the treatments in his , so they do them here, she denied the unit is normally stored on the table. She acknowledged the potential safety hazard it represented to residents.

b. On at 10:48 AM, Employee G, an unlicensed staff trained to assist residents with self-administration of medications was observed with Resident #27. The employee was intending to replace the resident's patch. She stated the old patch was not on the resident. She was asked and stated the resident's private duty aide (PDA) may have removed the patch, the resident may have removed the patch, or it may have come off in the shower. The PDA was nearby and was interviewed at the time. She stated she usually takes it off for the resident's shower, this occurs between 9:45 AM and 10:15 AM.

Review of Resident #27's medication record documented the patch was to be placed on the resident at 9:00 AM daily. There were no instruction for removing the patch prior to replacement with a new patch. This was brought to the RCD's attention on at 12:38 PM. She stated PDAs should not assist resident's with medications and stated the old patch should come off and the new patch should be applied at the same time for the purpose of continuous application of the medication.

Review of the facility's written protocol titled Private Duty Services dated documented, "PDA staff is expected to comply with established community policies/procedures ..."

c) On at 9:27 AM, the pill crusher unit used in the second floor wellness center was observed to be soiled with medication and other debris. At 11:43 AM, pill crusher unit used in the first floor wellness center was observed to be more soiled and had small amounts of rust in the area around the bottom fasteners. This was brought to the RCD's attention on at 11:43 AM.

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2) During initial observational tour of the BTR (Bridge to Rediscovery - Secured Unit) conducted with the ED (Executive Director), on , beginning at approximately 9:30 AM, the advocacy telephone numbers were not posted for resident use. The ED was asked to locate this mandatory posting. He was unable to locate it and he stated these numbers are posted in the hallway in the 1st floor AL (Assisted Living) section of the facility. He was asked if the residents on the BTR unit go over to the AL section of the facility. He replied that some do occasionally for activities, but he acknowledged not all residents participate and not on a regular basis. He was asked how the facility ensures the residents of the BTR have access to the advocacy numbers. He acknowledged that the residents of the BTR do not currently have access to that information. He stated he was not aware these numbers need to be posted on the separate BTR (secured) unit.

3) During initial observational tour of the BTR (Bridge to Rediscovery - Secured Unit) conducted with the ED (Executive Director), on , beginning at approximately 9:30 AM, a telephone for resident use was not observed. The ED was asked how the facility provides convenient unrestricted access to a private telephone for the residents that do not have a personal telephone. He stated all the resident has to do is ask a staff member and they can bring the resident to the Wellness office and they can use that corded phone or the staff member can obtain the cordless phone from the receptionist desk located in the AL (Assisted Living) section of the facility. He was asked if a resident could be left alone in the Wellness office to make a private call on the corded phone. He stated that a staff member would have to remain in the . He acknowledged this would not provide privacy for the resident. He was asked how convenient unrestricted access is ensured if a staff member has to obtain the phone or unlock the Wellness office for a resident to obtain access. He acknowledged the facility does not currently provide for convenient unrestricted access to a private telephone for the BTR unit. He was asked how unrestricted private access was ensured for the residents on the 1st and 2nd floors of the AL unit. He stated there is a portable phone at the front desk on the 1st floor. He stated all a resident has to do is ask for the phone and a staff member can get it for them. He was asked if the facility provided residents convenient access to a telephone without having to ask a staff member to obtain the telephone. He acknowledged that the facility does not currently have a method for a resident to obtain a phone independently (without having to ask a staff member to get the phone). The ED was asked if there is a method for the facility to provide convenient unrestricted private access to a telephone for the residents on the 2nd floor. He stated they have a corded phone in the Wellness Center.

During subsequent observation of the BTR with the Employee G, conducted on , beginning at approximately 9:20 AM, she was asked how the facility provides unrestricted assess to a private phone for the residents of this unit. She replied, if a resident needs to use the telephone we have a corded phone in the Wellness office. She acknowledged that the resident would not be left alone in this . She was reminded that method would not provide for privacy. She then stated there is a portable phone at the reception desk that staff could bring to a resident. She was asked how that method would provide for convenient unrestricted private access if a staff member has to obtain the telephone. She replied, "I don't know you would have to ask the Director of the BTR.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observations, interviews and record review, the facility failed to ensure unlicensed staff who assist residents with self-administration of medications had written orders from a health care provider (HCP) prior to

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changing form/use of medications for 1 of 12 sampled Residents (#32). Unlicensed staff were crushing medications without a specific order.

The findings include:

Medications systems review was conducted beginning at 8:43 AM. Resident #32 was assisted with self-administration of medications by an unlicensed staff member (Employee G). She was observed to crush and a multi- with

Review of Resident #32's 2013 medication record documented an order that read, ""[Okay] to crush med unless contraindicated". There were no written HCP orders to crush specific medications. Unlicensed staff must have specific instructions for each medication, and are not allowed to make judgements as to what medications are safe to crush.

This was brought to the facility's Resident Care Director's attention on at 8:45 AM. She acknowledged the requirement related to unlicensed staff assisting residents with self-administration of medications.

Class III

0160-Records - Facility 58A-5.024(1) FAC
Based on observation and interview it was determined the facility did not ensure all completed survey, inspection and complaint inspection reports and notices of sanctions and moratoriums issued by the agency within the last 5 years were available to all residents. Florida Statute 429.35(3) requires every facility to post a copy of the last inspection report of the agency for that facility in a prominent location within the facility so as to be accessible to all residents and to the public.

The findings include:

During initial observational tour of the BTR (Bridge to Rediscovery - Secured Unit) conducted with the ED (Executive Director), on beginning at approximately 9:30 AM, he was asked where the survey results were posted on this secured unit. He stated the survey results book is on the 1st floor at the receptionist desk. He was asked how this meets the requirement of being accessible to all residents if a copy is not posted and available to the residents of the BTR unit. He stated if a resident asked to see the results that a staff member could go get it and bring it back.

During subsequent observation of the BTR with the Director of the BTR, conducted on beginning at approximately 9:30 AM, she was asked how long the binder labeled survey results has been next to the microwave in the dining She replied, since you mentioned that it needed to be available to the residents.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

Administrator
Barrington Terrace At Boynton Beach
1425 S. Congress
Boynton Beach, FL 33426

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on . 2013 by representatives from 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 (30) 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/dso
Enclosure: State form 3020-3547
XG90

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