STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964707	04/22/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Indigo Palms	570 National Healthcare Blvd Daytona Beach, FL 32114	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced licensure complaint survey, CCR # 2014001666 was conducted on . 2014.
Indigo Palms had defi**ciencies found at the time of the visit.**

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review, and staff and resident interviews, the facility failed to provide a written record of significant changes for and behaviors for Resident #1 and #2, 2 of 3 sampled residents.

The findings include:

1) Review of the clinical record for Resident #1 revealed a Health Assessment dated . The resident had a diagnosis of . Under Nursing and Special Precautions it listed the resident was at risk for and needed assistance with activities of daily living. The resident's clinical record did not reveal any documentation of . The Director of Nursing (DON) was asked on at 11:20 a.m. if Resident #1 had any . He stated that the resident had two on . An internal Assisted Living Facility (ALF) incident Report (which was not part of the resident's clinical record) was completed for Resident #1. The DON stated that Resident #1 can become combative with care. The resident's Medication Record for 2014 revealed that an anti-ps medication, , was started on the 16th and Gel (another anti-ps medication) was scheduled to be given on the 22nd. A second internal ALF Incident Report on was completed that revealed while performing peir-care, the resident became combative and kicked the nurse in the lower abdomen and clutched and pulled the nurse's right wrist. This incident was not documented in the clinical record. The DON stated that the resident was not receiving any services. He confirmed the resident's behaviors and were not in Resident #1's record.

2) Resident #2's Health Assessment dated revealed a diagnosis of and that the resident received hospice services for . Per Director of Nursing on at 1:25 p.m. the resident had two , one on and one on . Internal Incident Reports were completed. Follow up services were provided by hospice nurses who applied dressings to a laceration to the head and cut to Resident #1's right hand. This incident was not documented in the the resients record and only hospice notes recorded which services were rendered after the incidents. The DON confirmed this on at 1:30 p.m.

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on observation and staff interview the facility failed to maintain an accurate daily Medication Observation

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Record (MOR) for one out of three sampled residents, (Resident #1).

The findings include:

Record review of the physician orders for Resident #1 dated revealed Flexeril 5 milligrams (mg) at 6am, 11am and HS (at bedtime).

Record review of Resident #1's Medication Observation Record (MOR) for 2014 revealed an order dated for Flexeril 5mg 1 tablet by mouth at bedtime. Handwritten staff initials were observed daily on the MOR at 9pm.

Further review of Resident #1's 2014 MOR revealed a handwritten order dated for Flexeril 5mg at 6am, 11am and HS. The handwritten times observed on the MOR next to the order were 6am, 11am, 6pm. Staff initials observed on the MOR for 6am, 11am and 6pm daily.

The MOR revealed that Resident #1 was receiving Flexeril 5mg four times daily instead of three times daily as physician ordered.

The Director of Nursing on at 1:00 p.m. confirmed staff was signing off an extra dose of the medication. She reported the medication technicians have been incorrectly initialing on the MOR. Resident #1 was recieving Flexeril 5mg three times a day, but the staff have been initially it as given four times a day.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation and staff interview, the facility failed to secure medications at all times for 1out of 5 sampled residents (Resident #1) and for 1 of 2 medication carts.

The findings include:

During initial tour o fthe fcaility on at 9 a.m., one of the two medication carts in the hallway was observed to be unlocked. Employee A was assigned to this cart. There were no staff observed nearby. Residents were observed next to the medication cart. Employee A was observed in the dining a resident. On at 9:05 a.m., Employee B confirmed the medication cart was unlocked.

On at 9:10 a.m. , Resident #1 was observed sitting in his wheelchair just outside of the dining A yellow pill was observed in the fold of his shirt. He was unable to answer what the pill was due to his diagnosis of moderate Employee C stated on at 9:12 a.m. that she was told by Employee A that there was a pill noted on the resident this morning and thought that Employee A removed it. Employee C stated that the pill on Resident #1 was a She confirmed that the medication was not secured. She reported that Resident #1 had scheduled four times a day. Employee C stated she gave Resident #1 this medication at 8 am this morning She stated she crushed this medication so it was not from her medication pass and she thought that it was from the night shift. She stated she did not see the pill

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when she gave him his morning medications.

The Medication Record was reviewed and the 8 a.m. dose was not signed off as given this morning. Employee C signed it in front of the surveyor.

Employee A was interviewed on at 9:20 am. She stated that she informed Employee C about the pill around 7:45 a.m. and confirmed that she did not remove it. She stated that she got the resident dressed this morning around 7 a.m. and did not see the pill. She reported that when she was bringing Resident #1 to the dining , she saw the pill. She stated the time was around 7:45 a.m.

Class III

0079-Staffing Standards - Levels 58A-5.019(4) FAC
Based on observation and staff interview, the facility failed to have enough qualified staff to provide resident care for 1 of 5 sampled residents (Resident # 4) who required assistance with toileting and for 10 unsampled residents for locomotion from the dining .

The findings include:

On at 9 a.m., facility staff was observed to escort 13 residents in wheelchairs from the dining the South hallway. Ropes were hung to re-entry into the dining . The residents sat in the hallway and were dependent on staff for locomotion. The residents all had some level of . The residents were placed side by side and blocked the width of the hallway.

While staff escorted residents out of the dining , Resident #4 was on her knees with her pants down and was crying. At 9:10 AM, two staff members, including Employee B, escorted Resident #4 out of the dining . The resident was able to ambulate on her own but she had and began wandering.

On at 9:20 a.m. , Resident # 4 was observed in the hallway outside of on her knees with her pants down and a male resident was standing next to her. The resident was observed crying.

On at 9:25 a.m., there were still 12 residents in the South hallway blocking passage. Resident #5 was observed pushing another resident in a wheelchair. She stated that she helped transport residents out of the dining to help out the staff.
Resident #4 was observed walking and crying. She arrived next to the medication cart just off the South hallway, she began to pull her pants down. Employee C, a Medication Tech, was present and told the resident not to pull down her pants. The surveyor asked Resident #4 if she had to go to the she stated yes. Employee C was informed that the resident stated she had to use the Employee C stated the resident frequently said she had to go to the Employee C looked around for a Resident Assistant and could not find one. She stated the Resident Assistants were assisting other residents. She took Resident #4 to the .

On at 9:30 a.m. Employee C was asked why all of the residents were escorted from the dining the hallway. She stated the residents were moved to allow the dining be cleaned. She stated that normally, the residents were escorted by hospice staff members to another location in the building on the back hall, however, all of the hospice staff were in a meeting. She reported that the facility staff was assisting the residents as soon as they could. Employee C reported that there were 14 residents receiving hospice services

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at the facility.

On at 10:15 a.m, the Director of Nursing (DON) stated the facility staff were responsible for transporting residents from the dining providing assistance with toileting and not the responsibility of the hospice staff. The DON reported that hospice was just there to support and help, not take over care. He reported that he had told his staff that many times, and that the residents are the facility's responsibility.

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC
Based on observation and staff interview, the facility to maintain a clean, comfortable, and functional environment which potentially effected all 51 residents residing at the facility (photographic evidence obtained).

The findings include:

1. On at 8:40 a.m., an observation was made of the back hallway in the facility. The hallway had several reclining chairs. One of the recliners was in ill repair. The material was worn through on the arm and head rest.

2. On at 9:50 a.m., belonging to Resident #2 was observed. The chair next to the bed had a brown stain on it. The wall along the closet had peeling paint. The resident's footboard and headboard had peeling clear plastic. There was a foam mat along the resident's bedside. The mat showed heavy dirt and stains. The housekeeper, Employee F, was present and stated that it was not her job to clean the floor mat. She stated it was either the resident assistants or hospice staff. She stated that the peeling paint on the wall was the responsibility of her boss, Employee E, who was both the Maintenance and Housekeeper Director. She stated that she worked 8 hours a day and when she left, it was up to the resident assistants to keep the clean.

3. On at 9:55 a.m., belonging to Resident #3 was observed. The resident had a micro fridge and the shelf underneath it was crumbling. There were some small rust-like spots on the bottom of the fridge. Inside the fridge, there was a small open freezer inside. The freezer had thick ice lining it. The Resident's couch had two brown stool- like stains. There was an unpleasant odor in In the shower, there was a mold-like substance in the grout. There was a small hole in blanket on the residents bed. The wall in Resident #3 's stains that appeared to be water stains. The peeling paint on the wall.

4. On at 10:25 a.m., the Maintenance/ Housekeeper Director was interviewed. He stated that he did not have a list of who had floor mats or a schedule when they should be cleaned. He did not have specific schedules when items were to be cleaned. There was not a maintenance schedule to defrost the refrigerators in resident He stated that the resident assistants and hospice also cleaned. He reported that he did not know who was ultimately responsible for cleaning specific items.

5. On at 12:15 p.m., an observation of the dining made. Resident #2 was sitting in her wheelchair. Her wheelchair had visible dust/ dirt debris on the side and spokes, and locks of the wheelchair.

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There were 10 chairs observed that had dirt and red stains on them.

6. The Director of Nursing was interviewed on ... at 12:30 PM. He stated that the dining chairs should be cleaned after each meal. He confirmed that Resident #2 ' s wheelchair did have thick debris on it and it should have been cleaned. He stated that housekeeping should be keeping all of these items clean, including the chairs in the dining ... He did confirm the one recliner showed wear due to one resident that liked to pick at it. He stated that when the Maintenance Director left his position, the Housekeeping Director did assume responsibility for his position and has been doing both jobs.

7. On ... at 2 PM. the hand rail outside of the ... ' 113 was noted to be in disrepair. One of the fasteners was loosened from the wall which caused the handrail to wobble and be unsecure. The Director of Nursing was present at the time of this observation and confirmed this.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Indigo Palms
570 National Healthcare Blvd.
Daytona Beach, FL 32114

Re: CCR #2014001666

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on 2014 by representatives 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 **2014** 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 surveyors. Should you have any questions please call this office at

Sincerely,

Lana Meyering

a Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

LW/PM/JM/sm
Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Jacksonville Field Office
921 N. Davis St., Bldg. A, Suite 115
Jacksonville, FL 32209
Phone (904) 798-4201; Fax (904) 359-6054