STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965313	01/08/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Carlisle Palm Beach, The	450 East Ocean Avenue Lantana, FL 33462	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D

0000-Initial Comments
An unannounced Relicensure survey was conducted on [redacted] and [redacted] at The Carlisle Palm Beach. The facility had a deficiency found at the time of the visit.

0054-Medication - Records 58A-5.0185(5) FAC
Based on record review and an interview, the facility failed to ensure the Medication Observation Record (MOR) was immediately updated each time medication was offered or administered, for 1 out of 11 sampled residents (Resident #11).

The findings include:

During review of the MOR's for Resident #11 on [redacted] the omission of documentation by nursing staff who administered medication to this resident was identified. The following medications were not documented as offered or administered as required:

a) [redacted] (pain medication)-not documented as given on [redacted] at 6:00 AM; [redacted] at 6:00 PM; and, [redacted] at 8:00 PM.

b) [redacted] medication)-not documented as given on [redacted] at 8:00 PM.

These errors were acknowledged by the Administrator and Assisted Living Director during interview on [redacted] at 3:00 PM.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Carlisle Palm Beach, The
450 East Ocean Avenue
Lantana, FL 33462

Dear Administrator:

This letter reports the findings of a State Relicensure Survey that was conducted on 2015 by a representative 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 days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after 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/jw
Enclosure
XG90

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