STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966154	**06/09/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
PALMS OF ST LUCIE WEST (THE)	**501 NW CASHMERE BLVD. PORT SAINT LUCIE, FL 34986**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An abbreviated unannounced Relicensure survey was conducted on 8-9, 2015 at The Palms Of St. Lucie West. The facility had deficiencies found at the time of the visit.

An unannounced Limited Nursing Services (LNS) Monitoring survey was conducted on , 2015 at The Palms Of St. Lucie West. The facility had no deficiencies identified at the time of the survey.

0052 - Medication - Assistance with Self-Admin - 58A-5.0185(3) FAC

Based on observation and interview, the facility failed to follow the proper procedures for providing assistance with self -administration of medication, for 3 out of 11 sampled residents (Resident #1, #11 and #14) observed during medication pass.

The findings include:

a) Observation on at 9:08 AM, found Resident #14 receiving the following medication (as documented on the MOR/Medication Observation Record for 2015): 40mg. At 9:08 AM, observation during assistance with self- administration of medication revealed Staff A, a Medication unlicensed staff member, assisted Resident #14 with self-administration of medication. Staff A sanitized her hands, put each of Resident #14's medication in a souffle cup, and gave the medication to the resident. Staff A observed Resident #14 take her medication and signed her MOR. Further review of the MOR revealed the ordered medication was to be given "before a meal". The resident had finished her breakfast when the medication was given to her.

During interview with Staff A at 11:30 AM on she acknowledged that the instructions for this medication were to be given before a meal and that she had given the resident her medication after breakfast. The findings were also acknowledged by the Resident Services Director during interview on at 11:30 AM. She stated the resident is now receiving her medication before breakfast, beginning today .

b) On at 8:55 AM, Staff A/Medication , removed the following medications for Resident #11 from the locked medication cart: 5 mg; , 1000 mcg; 81 mg; D3, 5000 mcg; 50 mg; 40 mg; 160-12.5 mg; and 150 mg. The staff member removed the pills from the individually sealed bubble-pack medication cards and placed them into a small plastic cup. She then placed the cup of medication in front of Resident #11 while she was seated at the dining awaiting breakfast. Resident #11 began to take the pills, and the staff member left the resident to retrieve a cup of tea from the kitchen. The staff member does not observe Resident #11 swallow all of her morning medications. After getting the tea, the staff member returned to the dining observe the resident swallow the remaining pills.
c) On at 8:45 AM, the Resident Services Director, who is a Licensed Practical Nurse, removed the following medications for Resident #1 from the locked medication cart located in the nurse's office in the locked Memory Care Unit (Bridges to Discovery): , 10 mg; , 1000 mcg; and , 100 mcg. The nurse removed the pills from the individually sealed bubble-pack medication cards

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and placed them into a small plastic cup. The nurse then crushed the pills into powder and mixed them with Resident #1's oatmeal. The nurse placed the bowl of oatmeal in front of Resident #1 while she was seated at the dining awaiting breakfast. Resident #1 began to eat the oatmeal, and the Resident Services Director returns back to the medication The does not observe Resident #1 eating the entire bowl of oatmeal containing her morning medications. After several minutes have passed, the returns to the dining check the resident's bowl to make sure it is empty of all oatmeal.

During interview with the on at 8:50 AM, she states, "We have had quite a time getting the resident to take her medications. She loves her oatmeal, so we have found that if we crush her meds and mix them with her oatmeal, she'll take them."
On at 12:45 PM, the acknowledges it is proper protocol to observe Residents take all of the medications given.

Class III

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 accurate and up-to-date for 2 out of 2 sampled residents (Resident #14 and #17).

The findings include:

On , the 2015 MOR for Resident #14 was reviewed and the following omissions were identified:

a) Patch 4.6mg, apply one patch every 24 hours-blank for 7 and 8, 2015

On , the 2015 MOR for Resident #17 was reviewed and the following omissions were identified:

a) 10mg, one tablet once daily-blank for , 2015
b) one tablet every 4 hours as needed for pain-blank on front page for 2015 (documented as given on back of MOR)

On at 11:30 AM, the Resident Services Director acknowledged these findings during interview.

Class III

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

Based on observation, record review and an interview, the facility failed to ensure physician's orders for a change in directions for use of a medication were on file before administering "crushed" medication to 2 out of 2 sampled

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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

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resident (Resident #1 and #2).

The findings include:

On between 8:45 AM and 9:00 AM, the Resident Services Director, who is a Licensed Practical Nurse, removed the following medications from the locked medication cart located in the nurse's office in the locked Memory Care Unit (Bridges to Discovery):

A. Resident #1 - , 10 mg; 1000 mcg; and , 100 mcg. The nurse removed the pills from the individually sealed bubble-pack medication cards and placed them into a small plastic cup. The nurse crushed the pills into powder and mixed them into Resident #1's bowl of oatmeal. The bowl was placed on the dining in front of Resident #1, and the resident proceeded to eat the oatmeal.

B. Resident #2 - 81 mg; , 10 mg; , 0.5 mg; , 50 mcg; and , 0.5 mg . The nurse removed the pills from the individually sealed bubble-pack medication cards and placed them into a small plastic cup. The nurse crushed the pills into powder and mixed them with applesauce. The nurse handed the small cup of applesauce containing the medications to Resident #2 , who proceeded to eat all of the applesauce.

On at 9:30 AM, after the medication observation, a review of Resident #1 and #2's medical record and Medication Administration Record was conducted for Physician Orders for crushed medications. No orders could be located. The Resident Services Director was asked to provide the physician orders for the crushed medications. After looking through the residents records, the stated, "I can't find the orders in the file. The Hospice nurse will be in this morning, and I will ask her for a copy." At 10:30 AM, a physician's order to crush all medications, dated was provided by the Hospice Nurse for Residents #1 and #2. There was no documentation provided by the facility showing there was a physician's order in place prior to that allowed staff to crush any of the medications for Resident #1 or #2.

Class III

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

Based on record review and an interview, the facility failed to ensure that 1 out of 3 sampled staff (Staff B) had freedom from documented by a health care provider on an annual basis. Under 58A-5.0131, F.A.C., " Health Care Provider " means a physician or physician ' s assistant licensed under Chapter 458 or 459, F.S., or advanced registered nurse practitioner licensed under Chapter 464, F.S.

The findings include:

The file for Staff B was reviewed for freedom from documented by a health care provider on an annual basis. There was documentation of this dated with only a signature of a licensed practical

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nurse/LPN (not a defined health care provider).

The Resident Services Directc was interviewed at approximately 11:30 AM on and confirmed that the documentation by a health care provider was not present and available for review. No additional documentation by a health care provider was presented at this time.

Class

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Palms Of St Lucie West (The)
501 NW Cashmere Blvd.
Port Saint Lucie, FL 34986

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 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. **Please forward documentation of correction to the Field Office.** Staff from this office will conduct an on-site visit 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 representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: State 5000-3547
XG90

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