STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965313	12/03/2015
NAME OF PROVIDER OR SUPPLIER **CARLISLE PALM BEACH, THE**	STREET ADDRESS, CITY, STATE, ZIP CODE **450 EAST OCEAN AVENUE** **LANTANA, FL 33462**	

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

0000 Initial Comments

A Limited Nursing Services monitoring visit was conducted at The Carlisle Palm Beach on 12/03/2015. The Carlisle Palm Beach had deficiencies at the time of the visit.

0008 Admissions - Health Assessment

Based on record review and interview, it was determined that the facility failed to maintain complete Resident Health Assessments for 2 of 3 residents reviewed.
The facility failed to note Resident #1 ' s status and that Resident #3 was at increased risk for due to the use of .

The findings included:

1) During a / Limited Nursing Services monitoring visit to the facility, the surveyor reviewed the Resident Health Assessment for Assisted Living Facilities (AHCA Form 1823) for Resident #1. The document review showed that the section of the health assessment titled or behavioral status was blank.

The Assisted Living director, who is also a Registered Nurse, confirmed the finding.

2)) During a Limited Nursing Services monitoring visit to the facility, the surveyor reviewed the / / Resident Health Assessment for Assisted Living Facilities for Resident #3. The document review showed that the section of the Health Assessment titled Special Precautions was blank. Page 2 of Resident #3 ' s Health Assessment indicates that the Resident requires staff assistance for all activities of daily living, including bathing, dressing, , and ambulation. Further review of the Resident ' s facility records revealed that Resident #3 was currently receiving 2.5 milligrams daily. However, the AHCA form 1823 didn't show any precautions related to this medication as noted by the pharmaceutical side effect .

The Assisted Living director, who is also a Registered Nurse, confirmed the findings.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965313	**12/03/2015**
NAME OF PROVIDER OR SUPPLIER **CARLISLE PALM BEACH, THE**	STREET ADDRESS, CITY, STATE, ZIP CODE **450 EAST OCEAN AVENUE LANTANA, FL 33462**	

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

N278 LNS - Records

Based on interview and record review, it was determined that the facility failed to maintain the required monthly nursing assessments, for 2 of 3 residents reviewed for provision of Limited Nursing Services (LNS).

The Findings included:

1) During a LNS monitoring visit, a review of Resident #1 ' s facility records revealed that the Resident ' s most recent monthly nursing assessment was dated . The finding was confirmed by the Assisted Living Director, who is also the LNS Nurse. The LNS Nurse confirmed that the Resident was receiving LNS services during , , and / , and that a monthly nursing assessment should have been completed during each of these months.

2) During a LNS monitoring visit, a review of Resident #2 ' s facility records revealed that the Resident ' s most recent monthly nursing assessment was dated . The finding was confirmed by the Assisted Living Director, who is also the LNS Nurse. The LNS Nurse confirmed that the Resident was receiving LNS services during / , and that a monthly nursing assessment should have been completed for , 2015.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

RE: Limited Nursing Services / Monitoring Visit

AMENDED LETTER

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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than 14, 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com

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.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida