STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968596	02/16/2016
NAME OF PROVIDER OR SUPPLIER **REGAL PARK ASSISTED LIVING, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1708 NE 4TH STREET** **BOYNTON BEACH, FL 33435**	

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

0000 Initial Comments

An unannounced Standard Relicensure survey was conducted on 02/15/2016 & ___ at Regal Park Assisted Living. The facility had deficiencies at the time of the visit.

0026 Resident Care - Social & Leisure Activities

Based on observation, interview, and record review, it was determined the facility failed to ensure that they provided scheduled activities at least 6 days a week for a total of not less than 12 hours per week on the Memory Care Unit of the facility.

The Findings included:

The activities calendar for the Memory Care Unit, dated 2016, that was provided after entrance conference indicated the following activities were scheduled:

Monday,
9:30 AM Music
10:30 AM Exercise
11:00 AM Soft Melodies
2:00 PM Painting
4:00 PM Circle Time (outside)
6:00 PM Walkabout

Tuesday,
9:30 AM Music
10:30 AM Exercise
11:00 AM Soft Melodies
2:00 PM Basketball
4:00 PM Sing-a-long
6:00 PM Walkabout

During observation of the Memory Care Unit on from approximately 9:00 AM - 2:30 PM there were no activities observed. During observation of the Memory Care Unit on / beginning at approximately 8:30 AM - 11:30 AM there were no activities observed.

During observation and interview with the Med Tech on beginning at approximately 11:30 AM, she stated the staff conducted a 10 minute ball toss this morning with the residents, but that was all

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the activities that was provided on this unit for the past 2 days. She stated that the Memory Care Supervisor has been off for the past 2 days and when she is not on duty that activities are not conducted with the residents on this unit as that is one of the Memory Care Supervisor's responsibilities. She was asked what activities are provided to the residents, on this unit, on the Memory Care Supervisor's scheduled days off. She replied no activities are provided on those days. During subsequent interview conducted with the Administrator on beginning at approximately 11:45 AM, she was informed that there had not been any activities conducted on the Memory Care Unit, except for a 10 minute ball toss that was reported by the Med Tech, for the 2 days of this survey. She stated she was not aware of this. She acknowledged that the Memory Care Supervisor had been off the 2 days of the survey.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation, interview, and record review, it was determined the facility failed to treat each resident with due recognition of personal dignity and the need for privacy for 1 of 8 sampled residents during medication observation (Resident #15). In addition, based on observation and interview it was determined the facility failed to post in full view in a common area accessible to all residents the telephone numbers for the Long-Term Care Ombudsman Program; Rights Florida; the Agency Consumer Hotline; and the toll-free Florida Hotline and failed to provide convenient access to a telephone to facilitate unrestricted and private communication for all the residents of the memory care unit.

The Findings included:

1) During medication observation conducted with the medication tech on beginning at 12:05 PM, she was observed to approach Resident #15 at the dining while Resident #15 was consuming her lunch and provide assistance with the self administration of eye drops. There was 2 other residents seated at this table that were also consuming their lunch at this time. All memory care residents had been served their lunch meal and were seated in this dining the time of this observation.

During interview conducted with the DON (Director of Nursing) on / beginning at approximately 1:55 PM, she was asked what is the facility's expectation of the provision of privacy when a medication tech is providing assistance with eye drops. The DON stated the expectation would be for

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the staff member to take the resident to their room or to the medication room to provide assistance with the self administration of eye drops. She was informed that Staff A had provided eye drops to Resident #15 during her lunch meal at the dining room table and in front of tablemate's and a of other residents consuming their lunch. The DON stated this was not an acceptable practice.

2) During initial tour of the memory care unit conducted with the Administrator, on / beginning at approximately 9:30 AM, the Administrator was asked where the advocacy numbers were posted. She stated she had asked a staff member to post them, but that she did not see them at this time. She was asked where a telephone that residents can make a private phone call was located on this unit. She stated this unit does not have one and that she was not aware of the requirement for memory care units to have a phone for resident use. She asked Staff A if residents had phones in their . Staff A replied that they do not have phones in their .

Class III

0054 Medication - Records

Based on record review and staff interview, the facility failed to ensure medication records for 4 of 4 residents, whose medication records were reviewed, included any missed dosages, refusals to take medications as prescribed, and/or was immediately updated each time the medications were offered or administered (Residents #1, #4, #7, and #8).

The findings include:

The Medication Observation Record (MOR) was reviewed for Residents #1, #4, #7, and #8. The following issues were found:

A) Resident #1:
1) The MOR was not initialed by Med Tech on / for 8 PM offering of ;

2) No Med Tech initials on / for 8 PM dose of and ;

3) No Med Tech initials on / for 5 PM dose of Sucralfate, 8 PM dose of , 3 PM and 11 PM wrist check, 9 PM dose of , 8 PM dose of , and 5 PM dose

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of ;

4) No Med Tech initials on 2/13/16 for 7 AM dose of , 8 AM/12 PM/ 5 PM doses of Sucralfate, 8 PM dose of , 7 AM - , 7 AM C, 7 AM D, 7AM/3 PM/11 PM wrist check, 9 PM dose of , 8 PM dose of , and 5 PM dose of .

5) Only one medication note was added on back of MOR: " / 12:00 Out of facility at Dr's Appt". Noon meds are initialed for .

B) Resident #4
1) No Med Tech initials on for 3 PM wrist check.

2) No Med Tech initials on / for 8 PM dosage of .

C) Resident #7
1) On - / , Med Tech's initialed and circled the 8 AM/1 PM/5 PM medication times.

2) On , 8 AM and 1 PM doses are initialed, but 5 PM dose has a "0" in the box.

3) On back of MOR, a medication note was added for (8 AM, 1 PM and 5 PM) , / (8 AM and 1 PM) and (5 PM) which states, "waiting on pharmacy." No Medication Note for / , / or .

4) No Med Tech initials on / for 5 PM dose of , 9 PM dose of , 5 PM dosage of , , 3 PM/11 PM wrist check, and 5 PM dose of .

5) No Med Tech initials on / for 8 AM and 5 PM doses of , 7 AM dose of , 9 PM , 7 AM dose of , 8 AM and 5 PM dose of , and 7 AM/3 PM/ 11 PM wrist check.

D) Resident #8
1) From (5 PM dose) until (8 AM dose), Med Techs initialed and circled the 8 AM and 5 PM medication times for -Acetaminiphen.
Medication Notes on back of MOR, dated for 9 AM and 5 PM dose and , document

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"waiting on pharmacy." No Medication Note for - and / .
No Med Tech initials for 9 PM dose of .

2) On 2/15/16 at 8:50 AM, the Med Tech providing medication assistance in the unsecured area of the facility was shown the empty boxes on Resident #1 and Resident #4's MOR; she did not provide any explanation as to the lack of Med Tech initials.

On / / at 1:20 PM, the Administrator acknowledged the lack of Med Tech initials and documentation on the MOR for these 4 residents.

Class III

0056 Medication - Labeling and Orders

Based on observation, interview, and record review, it was determined the facility failed to obtain an order for crusing a resident's medication, for 1 of 8 sampled residents observed related to medications (Resident #19) and the facility failed to provide a physician ordered medication in a timely manner, for 3 of 8 sampled residents observed related to medications (Resident #15, Resident #7, and Resident #8).

The Findings included:

1) During medication observation and record review conducted with the Staff A on beginning at approximately 8:50 AM, Resident #19's medications as followed were crushed and placed in chocolate pudding:

a) D 1000 units (daily)
b) 40mg (daily)
c) with (daily)
e) Sod ER 250mg (twice daily)
f) 0.025mg (30 minutes before breakfast)
g) C 500mg (twice daily)

Review of Resident #19's 2016 MOR (Medication Observation Record) did not reflect any medications were to be crushed. Review of Resident #19's physician's orders for medications did not reflect any medications were to be crushed. Staff A was asked why she crushed this resident's medications and she replied because she knows they are to be crushed. Staff A was provided the opportunity to locate any documentation related to crushing Resident #19's medications and she could

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not locate any. She also acknowledged that the medication labels did not reflect medications were to be crushed.

During subsequent interview and review of this resident's medical record conducted with the Administrator, on beginning at approximately 9:50 AM, she acknowledged this resident's record did not reflect any orders for Resident #19's medications to be crushed. Resident #19's most recent health assessment, dated , noted diet consistency as regular. The last physician's note, dated , did not reflect crushing her medications or any changes in diet order for this resident. The Administrator was provided the opportunity to locate any physician's order related to crushing of medications and she was not able to locate any.

2) During medication observation and record review conducted with the medication tech on beginning at approximately 12:05 PM, she was observed to provide assistance with the self administration of Resident #15's 0.3% eye drops (instill 1-2 drops into affected eye every 4 hours for 7 days). Review of Resident #15's 2016 MOR (Medication Observation Record) reflected this medication was provided for the first time on at 8:00 AM. Review of Resident #15's physician's orders indicated the eye drops were ordered on by this resident's physician. The physician's note, dated , reflected (both) eyes were crusty, (containing or producing pus) discharge; and was diagnosed at this time. The medication tech acknowledged that today was the first day this resident received this medication and that the order and physician's note were dated .

During subsequent interview conducted with the DON (Director of Nursing) on beginning at approximately 1:55 PM, she was informed that Resident #15 was provided with her eye drops for the first time on at 8:00 AM and that the physician's order was dated . She was asked what the facility's expectation is related to the time frame of a medication order to be filled and provided by the pharmacy and to the resident. She stated 24-48 hours. She was asked what she thought about a 6 day time frame for a resident with . She stated this was not acceptable.

Review of the CDC's (Center for Control) website indicated (also known as pink eye) is an of the thin clear tissue that lines the inside of the eyelid and the white part of the eyeball. The symptoms are noted as: redness or ; increased tears; white, yellow, or green eye discharge; itchy, irritated, or of the eyes; increased sensitivity to light; gritty feeling of the eye; and crusting of the eyelids or lashes.

During interview with the Administrator, conducted on beginning at approximately 8:30 AM,

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she was asked to locate the pharmacy delivery sheet for Resident #15's eye drops. She subsequently provided this documentation for review and acknowledged that it noted / as the delivery date. The Administrator could not provide an explanation as to why it took until for Resident #15 to have been provided her eye drops (for) for a medication that was ordered on and delivered on / .

3) Review of Resident #7's Medication Observation Record reveals Resident #7 was waiting on the pharmacy to deliver his for at least 5 days. The resident missed the 8 AM, 1 PM, and 5 PM dose of this medication on , , , , and . It is also documented resident was waiting on pharmacy for 's 5 PM medication. It is unclear as to if the resident received any on / at 8 AM or 1 PM, as Med Tech(s) did initial without any further documentation.

4) Review of Resident #8's Medication Observation Record reveals Resident #8 was waiting on pharmacy to deliver his - for at least 6 days. Resident #8 missed 5 PM dose of medication on , and both the 8 AM and 5 PM doses on - . The order for , was re-written on / and resident received medication at 5 PM.

Class III

0078 Staffing Standards - Staff

Based on interview and record review, it was determined the facility failed to ensure that each newly hired staff member, within 30 days of beginning employment, had submitted a written statement from a health care provider documenting that the employee does not have any signs or symptoms of communicable , for 3 of 5 sampled employee files reviewed (Staff A, Staff B, and Staff D).

The Findings included:

During employee record review and interview conducted with the Administrator, on beginning at approximately 11:20 AM, she was provided the opportunity to locate documentation from a health care provider that indicated the following employees were free from signs and symptoms of communicable :

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a) Staff A: a medication technician with a date of hire noted as / (is 30th day of employment with the facility)
b) Staff B: a medication technician with a date of hire noted as
c) Staff D: the Administrator with a date of hire noted as 01/

At the time of this review and interview, the Administrator was not able to locate any documentation for Staff A that reflected they were free of signs and symptoms of communicable . The Administrator was able to locate documentation for Staff B and Staff D, however, this documentation was not signed by the health care provider indicating freedom from signs and symptoms of communicable . The Administrator acknowledged this documentation was not signed by the health care provider.

Class III

0093 Food Service - Dietary Standards

Based on observation, interviews, and record reviews, it was determined the facility failed to ensure that each resident received the nutritional requirements noted on the menu developed by the Registered Dietitian in the Memory Care Unit; that the menu was reviewed annually by a Registered Dietitian, licensed dietitian or licensed nutritionist; that the current menus were conspicuously posted or easily available to the residents and that substitutions were noted before or when the meal is served.

The Findings included:

1) During lunch observation conducted with the Administrator on the Memory Care Unit, on beginning at approximately 12:00 PM, Resident #17 was observed to have been served one single bowl of orange colored puree. The other residents were served pasta with marinara, garlic bread, cooked carrots, and chocolate cake with white frosting. The Administrator was asked to identify what food was in the bowl. She stated she assumed it to be the pasta and meat sauce. During subsequent interview conducted with the interim Food Service Manager, on beginning at approximately 12:35 PM, he acknowledged that only pasta with meat sauce must have been sent to this resident. He could not provide an explanation as to why she was not provided with the cooked carrots. He stated he was not aware garlic bread or cake could be pureed.

At the time of this interview, the Administrator also acknowledged that there was no menu posted in the Memory Care Unit at this time and therefore, the substitution of the cooked carrots for the salad was not posted as well. She could not provide an explanation as to why the menu and substitution was not

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posted on this unit.

Review of Resident #17's health assessment, dated 09/16/2015, indicated she is to receive a puree diet and has the diagnoses of (oral phase); , and

2) During observation and interview conducted with the Administrator and the Med Tech on the Memory Care Unit during breakfast on / beginning at approximately 9:00 AM, residents were observed to be served oatmeal, scrambled eggs, and hashbrowns. There was no beverages served to the residents on this unit with their meal. The Med Tech acknowledged the residents did not receive orange juice this morning. The Administrator informed the Med Tech that coffee would be coming to this unit, soon. The menu that was provided for review indicated the residents were to have received sausages; peaches; and juice. None of these items were served during this meal service. This was acknowledged by the Med Tech and the Administrator.

3) During lunch observation in main dining / , residents were served a meal consisting of lasagna, sliced carrots, garlic toast and a small piece of chocolate cake (approximately 1/2 inch square). A review of the weekly menu posted on the dining near kitchen entrance showed lunch meal for "Monday" was to include salad of the day, kielbasa sausage, carrots, potatoes, cabbage, rye bread, and dessert of the day or fruit. A closer look at the posted weekly menu revealed a note next to Registered Dietician's signature which stated menu "approval to 2016". From the time the menu was observed (12 Noon) until a photo was taken of the menu (1:30 PM), a mark appeared on top of the last two digits of the year "2016" which made the year illegible.
Daily menus for lunch and dinner were posted next to buffet containing coffee set-up in the dining , but the date on these menus was for the previous week, 11 and 12, 2016.

A request was made to the Administrator for current approved dietary menu on at 9:45 AM. A copy of a weekly menu, approved by Registered and Licensed Dietician (RD/LD) was submitted for review on at 1:00 PM. This menu was not dated by the RD/LD, and did not specify the time period for which this menu would be valid.
During interview with the Administrator on at 1:10 PM, she stated she would provide documentation showing dates for which the menu had been approved; however, this documentation has not yet been received.

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Class III

0162 Records - Resident

Based on interview and record review, it was determined the facility did not obtain documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, for 1 of 2 sampled resident records reviewed (Resident #15).

The Findings included:

During record review and interview conducted with the Administrator, on / beginning at approximately 11:25 AM, Resident #15's admission paperwork (including residency agreement and informed consent for unlicensed staff to assist with the self-administration of medications) was noted to be signed by Resident #15's daughter. The Administrator was provided the opportunity to locate a copy of Resident #15's daughter's documentation of appointment as health care surrogate, health care proxy, guardian, or power of attorney. The Administrator was not able to locate this documentation in the residents records (administrative or clinical). The Administrator then proceeded to contact Resident #15's daughter to inquire as to the status of this documentation. The Administrator reported that the daughter does not have any of these appointments for Resident #15.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

....., 2016

Administrator
Regal Park Assisted Living, Inc
1708 NE 4th Street
Boynton Beach, FL 33435

RE: Relicensure Survey

Dear Administrator:

This letter reports the findings of a Relicensure survey that was conducted on , 2016 and , 2016 by a representative 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 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 18, 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
Enclosure
XG90

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