STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11910386 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CITY WALK ACTIVE LIVING	534 DATURA STREET WEST PALM BEACH, FL 33401

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0010 Reg. # 429.26(1&9) FS; 58A-5.0181(4) FAC LSC	Correction Completed	ID Prefix A0053 Reg. # 58A-5.0185(4) FAC LSC	Correction Completed	ID Prefix AZ815 Reg. # 408.809, 435.02(2), 435.06 LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) AW	DATE 4/8/16	SIGNATURE OF SURVEYOR [signature] for A. Smith	DATE 4/8/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 12/22/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: DHYJ12

STATE FORM: REVISIT REPORT ( )

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910386	R 03/17/2016
NAME OF PROVIDER OR SUPPLIER **CITY WALK ACTIVE LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **534 DATURA STREET** **WEST PALM BEACH, FL 33401**	

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

0000 Initial Comments

An unannounced follow-up inspection was conducted from 03/16/2016 to 3/17/2016 at City Walk Active Living assisted living facility (ALF).

This ALF was not in compliance during this follow-up inspection.

0052 Medication - Assistance with Self-Admin

Based on observation and interview, it was determined that the facility failed to provide assistance with self-administration of medication as directed under 429.256 FS, for 4 of 4 residents observed for the provision of assistance with the self-administration of medications. The Medication Assistant failed to identify the medications provided to Residents #1, #2, #3 and #4.

The findings included:

1. During a 7:05 AM observation of medication provision for Resident # 1, the surveyor observed the following:
The Medication Assistant (MA) checked the Resident's medication observation record. The MA then sanitized her hands, removed Resident #1 ' s pharmacy labeled medication cards from the medication cart, and pushed medications from the cards into a medication cup. MA then returned the medication cards to the medication cart.
The MA then took the cup containing the medications to the Resident who was seated in a chair. The MA handed the cup and a cup of water to Resident #1 and observed the resident swallow his medications. During this observation, at no time did the Medication Assistant identify the medications being provided to the Resident.

2. During a 7:15 AM observation of medication provision for Resident # 2, the surveyor observed the following:
The Medication Assistant (MA) checked the Resident's medication observation record. The MA then sanitized her hands, removed Resident #2 ' s pharmacy labeled medication cards from the medication cart, and pushed medications from the cards into a medication cup. MA then returned the medication cards to the medication cart. The MA then took the cup containing the medications to the Resident who was seated in a chair. The MA handed the cup and a cup of water to Resident #1 and observed the resident swallow her medications. During this observation, at no time did the Medication Assistant identify the medications being provided to the Resident.

3. During a 7:20 AM observation of medication provision for Resident #3, the surveyor

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observed the following:
The Medication Assistant (MA) checked the Resident's medication observation record. The MA then sanitized her hands, removed Resident #3 ' s pharmacy labeled medication cards from the medication cart, and pushed medications from the cards into a medication cup. MA then returned the medication cards to the medication cart. The MA then took the cup containing the medications to the Resident who was seated in a chair. The MA handed the cup and a cup of water to Resident # 3 and observed the resident swallow his medications. During this observation, at no time did the Medication Assistant identify the medications being provided to the Resident.

4. During a 7:30AM observation of medication provision for Resident # 4, the surveyor observed the following:
The Medication Assistant (MA) checked the Resident's medication observation record. The MA then sanitized her hands, removed Resident #4 ' s pharmacy labeled medication cards from the medication cart, and pushed medications from the cards into a medication cup. MA then returned the medication cards to the medication cart. The MA then took the cup containing the medications to the Resident who was seated in a chair. The MA handed the cup and a cup of water to Resident #4 and observed the resident swallow her medications. During this observation, at no time did the Medication Assistant identify the medications being provided to the Resident.

The Medication Assistant was interviewed immediately after providing the Residents with their medications. The MA stated that she doesn't identify the medications to the residents.

In an interview with the Executive Administrator on at 12:30 PM, she stated that all medication assistants had recently been retrained on the proper assistance with self administration of medication procedures, which included to inform the resident what medications they were being provided by the medication assistant.

Class III

0055 Medication - Storage and Disposal

Based on observations, record review and interviews, the facility placed residents at-risk by failing to follow facility operating procedures by ensuring centrally stored medications were maintained in a locked storage receptacle and free of dampness.
Findings include:
During a tour of the facility on beginning at 7:00 AM, a line of 8 residents was observed by the

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first floor nurse ' s station waiting to receive their medication from the nursing staff.
While continuing to tour the first floor nurses station on at 7:00 AM, the nurse ' s station door was observed standing open with the lights on. Both medication cart locks were observed in the unlocked position and the medication storage drawers could be opened. It was observed that a set of keys were laying on top of medication cart #1. It was observed when the nursing staff returned to the nurse ' s station, they picked up the keys on medication cart #1 and locked both medication carts.
While continuing to tour the first floor nurses station on at 7:00 AM, unsecured medication was observed sitting on top of the nurse ' s desk and on top of the mini-refrigerator and the mini-refrigerator was observed to be unsecured with no locking mechanism and contained resident medication inside.
During a tour of the facility on at 7:00 AM, a line of 10 residents were observed waiting for their medication by the first floor nurses station.
While continuing to tour the first floor nurses station on at 7:00 AM, it was observed the mini-refrigerator was unsecured with no locking mechanism and contained resident medication inside of the mini-refrigerator. It was observed the bottom of the refrigerator, where the resident medication was sitting, was covered in water and the medication bottles were damp.
In a record review on of the facility ' s operating procedure regarding medication storage indicates centrally stored medication must kept in a locked cabinet at all times, located in an area free of dampness, if stored in a refrigerator it must be locked and staff must have ready access to keys to the medication storage at all times.
In an interview on at 11:11 AM with the administrator, the administrator stated " ready access to keys, " means the staff should have the keys on their person at all times.

Class III

0165 Risk Mamt & QA: Adverse Incident Report

Based on record reviews and interviews, the facility failed to file adverse incident reports for three incidents which resulted in law enforcement investigation.
Findings include:
In an interview on at 11:11 AM with the executive administrator and the administrator, the administrator stated all of the adverse incident reports filed with the state are located in the adverse incident book. The executive administrator stated the facility has filed an adverse incident report each time they have contacted law enforcement.
On during a record review of local law enforcement calls to service, the calls to service documented law enforcement investigated two incidents not documented by the facility as adverse incidents. The dates of those include / and / .
On during a record review of local law enforcement investigation reports dated / , the

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investigation report documented law enforcement was contacted on 1/5/16 because Resident #6 had eloped from the facility. The investigation report documents law enforcement was contacted by the executive administrator of the facility. The investigation report documents law enforcement made attempts to contact Resident #6 ' s family.
In an interview with the executive administrator on at 12:30 PM, the executive administrator stated she had been informed by staff on the evening of I/ that resident #6 had not returned to the facility after being out with her family. The executive administrator stated Resident #6 was not identified as an elopement risk and Resident #6 routinely ambulated throughout the facility property unless going out with her family. The executive administrator stated she was concerned for Resident #6 ' s safety and felt she was at-risk so she called the resident ' s family to inquire about the resident. The executive administrator stated she was informed Resident #6 was not with her family, so she contacted local law enforcement to file a missing person ' s report. The executive administrator stated she contacted local hospitals and was able to locate the resident.
In an interview with the administrator on at 12:40 PM, the administrator stated he had not completed an adverse incident report after the incident.
In a record review on of Resident #6 ' s file, the file documents Resident #6 was admitted to the facility on with a diagnosis of and . Resident #6 ' s file documents on Resident #6 ' s Agency for Health Care Administration (AHCA) 1823 health assessment Resident #6 requires medication management and daily observation of her well-being and whereabouts.
On during a record review of a local law enforcement investigation report dated I/ , the law enforcement report documents law enforcement has an open and ongoing criminal investigation for allegations of assault on Resident #5
In an interview on at 11:50 AM with a local law enforcement detective, the detective indicated the investigation is ongoing.
In an interview on at 12:15 PM with the resident care coordinator, the resident care coordinator stated she had been contacted in 2015 by law enforcement concerning their investigation about an alleged assault of Resident #5. The resident care coordinator stated she documented the incident in resident #5 ' s observation records.
In a continued interview on at 12:15 PM with the resident care coordinator, the resident care coordinator stated she had been contacted on I/ concerning the incident of an alleged assault. The resident care coordinator stated she documented the contact in the observation notes of Resident #5.
In a record review on of the Agency ' s adverse incident reports, it does not provide any documentation of the facility filing adverse incident reports related to the elopement on I/ and the allegations of assault on and I/ .

Class III

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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
City Walk Active Living
534 Datura Street
West Palm Beach, FL 33401

Dear Administrator:

This letter reports the findings of a **second** State Licensure Revisit Survey conducted on 16-17, 2016 by representatives of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit. You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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
Enclosures: State form 5000-3547 and State revisit report

YOSF

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