STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966872	04/13/2016
NAME OF PROVIDER OR SUPPLIER **CHRISTEL CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **4973 BROADSTONE CIRCLE** **WEST PALM BEACH, FL 33417**	

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

0000 Initial Comments

An unannounced change of ownership (CHOW) survey was conducted on 13, 2016 at Christel Care Inc. The facility had deficiencies at the time of the visit.

0054 Medication - Records

Based on record review and an interview, the facility failed to maintain an accurate and up-to-date Medication Observation Record (MOR) for 2 out of 5 sampled residents (Resident #2 and #5).

The findings included:

On at 1:00 PM, the 2016 MOR's for Resident #2 and #5 were reviewed. The following omissions were identified:

a) Resident #2 had prescribed listed medications, and , that were not documented as given by facility staff from through .

b) Resident #2 had a pharmacy labeled container of 600mg, one tablet to be given every 8 hours, that was held by the Administrator and not listed on the MOR. The Administrator confirmed during interview at this time that the resident received assistance with self-administration of all medication and that there was no "may self administer without assistance" order on file for this medication to be kept with the resident or not in centrally stored medications.

c) Resident #5 had a prescribed medication, , that was not documented as given at noon by facility staff on / through .

These omissions were acknowledged during interview with the Administrator at this time. No additional documentation was presented.

Class III

0056 Medication - Labeling and Orders

Based on observation, record review and an interview, the facility failed to ensure every reasonable effort was made to refill medication for 1 out of 5 sampled residents (Resident #2).

The findings included:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966872	04/13/2016
NAME OF PROVIDER OR SUPPLIER **CHRISTEL CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **4973 BROADSTONE CIRCLE** **WEST PALM BEACH, FL 33417**	

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

On 4/13/16 at 12:00 PM, Resident #2 stated he was having pain and asked for medication for pain. The resident's 2016 Medication Observation Record (MOR) was reviewed at this time and indicated the resident had " 325mg, two tablets, to be given every 4 to 6 hours" for pain. The resident's MOR also indicated he had a prescription for ( ). Review of the resident's MOR and his medications revealed there was no supply of the or available in centrally stored medication for this resident. The Administrator stated during interview at this time that she did not know how long the resident had not had these two prescribed medications, but that he had not had them for the month of 2016, since , 2016. She did not know if the resident's medications were to be refilled or if they were to be discontinued. Review of the resident's records showed no documented attempts to obtain a refill of the prescribed medication.

Class III

0080 Training - Core & Competency Test

Based on record review and an interview, the facility failed to ensure the administrator had completed CORE training and the competency test within 3 months from the date of appointment.

The findings included:

On at 1:00 PM, the personnel file for the administrator was reviewed and did not include documentation of CORE training and passing of the competency examination established by the Department of Elder Affairs (DOEA). The administrator stated during interview at this time that she was unaware that the training was required to be completed within 3 months of becoming the administrator and confirmed that she had been the administrator since . She acknowledged that she had not completed CORE training, including passing the competency test.

Class III

Z814 Background Screening Clearinghouse

Based on record review and an interview, the facility failed to ensure they had registered with the clearinghouse (the Agency's criminal background screening website) and had maintained the employment status on the website of all employees.

The findings included:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966872	**04/13/2016**
NAME OF PROVIDER OR SUPPLIER **CHRISTEL CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **4973 BROADSTONE CIRCLE** **WEST PALM BEACH, FL 33417**	

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

On 4/13/16 at 1:00 PM, the Administrator stated during interview that she had not registered an account for the facility with the Agency's criminal background screening website (the clearinghouse) and had not updated any employees' status on the site. She was unaware of this requirement. Review of the Agency's website revealed no current account for this facilty with all current employees listed on the roster.

Class

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Christel Care Inc
4973 Broadstone Circle
West Palm Beach, FL 33417

RE: Change of Ownership (CHOW) survey

Dear Administrator:

This letter reports the findings of a CHOW state licensure survey that was conducted on 13, 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 , 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/dso
Enclosure
XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com