STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965313	06/17/2016
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

An unannounced Relicensure survey with Limited Nursing Services (LNS) was conducted on 17, 2016 at The Carlisle Palm Beach (License #9713). The facility had deficiencies at the time of the visit.

0052 Medication - Assistance with Self-Admin

Based on observation, interview, and record review it was determined the facility failed to assist residents with the self-administration of medications in accordance with procedures described in Section 429.256, F.S. and this rule specifically related to failure to provide assistance with the self administration of medications in a timely manner, for 2 of 9 sampled residents (Residents #5 and #9).

The findings included:

During medication pass with Staff C conducted on , assistance with the self administration of medications to the following residents was observed. Their scheduled 8:00 AM medications were provided as follows:

1) Resident #5's 8:00 AM medications were provided on / beginning at 9:15 AM.
a) tablet 40mg, once daily before a meal
b) 1 1/2 tablets, three times daily before meals

2) Resident #9's 8:00 AM medications were provided on beginning at 10:00 AM.
a) tablet, once daily
b) 1GM tablet, once every morning and every evening

During interview with Staff C and the Memory Care Director conducted on at 1:45 PM, the aforementioned medications that were listed on the residents' 2016 MORs to be given at 8:00 AM were discussed. They acknowledged that the times on the MORs for these medications could be changed to 9:00 AM when these residents received the other morning medications that they were assisted with to ensure the medications were provided timely (within one hour of the scheduled time). These findings were also discussed with the Administrator and Memory Care Director at 3:30 PM on .

Class III

0086 Training - ADRD

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Based on record review and an interview, the facility failed to ensure that 1 of 3 sampled staff (Staff B) who have regular contact with or provide direct care to residents with ADRD (and Related) in this facility that maintained a secured area had obtained 4 hours of annual update training in ADRD.

The findings included:

The personnel file for Staff B, a "med tech" who provided direct care to residents in the secured unit, was reviewed for training in ADRD. The file did not contain documentation of 4 hours of annual update training dated within the previous year. The following training was documented and available for review:

a) Staff B-Date of Hire / ;
4 hours of ADRD training Level I completed after hire on / (more than 3 months after hire).

During interview with the Administrator and Memory Care Director at 3:30 PM on , they acknowledged the staff member did not have documentation of continuing education on an annual basis (4 hours in ADRD), dated within the previous year. The facility provided no additional information for review.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 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 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 representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

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