STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910385	07/28/2016
NAME OF PROVIDER OR SUPPLIER **TROPICAL GARDEN VILLAS INC. (H**	STREET ADDRESS, CITY, STATE, ZIP CODE **432 SOUTH 'F' STREET** **LAKE WORTH, FL 33460**	

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

0000 Initial Comments

An unannounced licensure complaint survey, CCR# 2016004594, was conducted on 7/15/16 and completed on 7/28/16 at Tropical Garden Villas (Home), License #5553,. The facility had deficiencies at the time of the investigation.

0010 Admissions - Continued Residency

Based on resident record review and staff interview, it was determined the facility failed to ensure each resident was assessed for continued residency, for 5 out of 12 sampled records reviewed. As evidence of the facility failure to ensure the following;
1) health assessments (AHCA Form 1823) were; updated at least every 3 years for 2 of 12 residents (Residents #2 and #7);
2) filled out in their entirety for 2 of 12 residents (Residents #3 and 5)
3) complete with all 5 pages of AHCA Form 1823 within the Resident's file for 2 of 12 residents (Residents #2 and #4)

Findings include:

1) Resident #2:
a) Resident's most current AHCA Form 1823 was missing page 1 of the Form, which contains Resident's height and weight, diagnoses, and any physical or sensory limitations, or behavioral status, nursing/treatment/ requirements, and special precautions.
b) The date on the most current ACHA Form 1823 was / . Per regulation, a new health assessment must be completed at least every 3 years.

2) Resident #3:
a) Page 5, Section 3 (Services Offered or Arranged by the Facility for the Resident) of AHCA Form 1823 was not completed.

3) Resident #4 :
Pages 3 and 4 were missing from this resident's AHCA Form 1823. Page 3 includes information Self-Care and General Oversight Assessments, and Page 4 includes current medications, whether resident needs medication assist or administration, and the health care provider's signature, credentials, and date of assessment.

4) Resident #5:
a) Page 2, Section 1, part D of the Resident's ACHA Form 1823 contained no indication the resident's

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910385	07/28/2016
NAME OF PROVIDER OR SUPPLIER **TROPICAL GARDEN VILLAS INC. (H**	STREET ADDRESS, CITY, STATE, ZIP CODE **432 SOUTH 'F' STREET** **LAKE WORTH, FL 33460**	

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

needs can be met in an assisted living facility which is not a medical, nursing, or facility.
b) Page 5, Section 3 has not been completed.

5) Resident #7:
a) Resident's most current AHCA Form 1823 contained in Resident's file was dated . Per regulation, a new health assessment must be completed at least every 3 years.

During interview with the Administrator and Facility Manager on / at 12:15 PM, they acknowledged the multiple concerns with the resident health assessments.

Class III

0054 Medication - Records

Based on medication record review and interviews, the facility staff failed to ensure accurate documentation on the Medication Observation Records (MORs), for 1 of 12 residents (Resident #6).

The findings include:

On / , a review was conducted of the 2016 MOR for Resident #6. The review revealed the following:
a) ER 500 mg, to be given 3 times per day (8 AM, 5 PM, and 8 PM), was not documented as given at 8 PM on any date in ,
b) The 5 PM dose of ER 500 mg was not documented as given on / .
c) 5 mg, to be given 2 times per day (8 AM and 5 PM), was not documented as given at 5 PM on .
There is no notation on back of MOR as to why these doses were not provided.

An inspection of the pre-packaged 8 AM, 5 PM, and 8 PM medication cards for Resident #6 contained all the medication to be given at these specific times, enclosed together in one sealed plastic bubble on the medication card. The ER 500 mg is listed on the 8 PM medication package. The card for the 8 PM meds had the packets torn from the card for the days leading up to / . However, there was no documentation proving the was provided to the resident.

Interview was conducted with the facility's Manager on at 12:25 PM. She could not provide an answer as to why the MOR was not signed on any of the days in for the ER 8 PM medication time.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910385	07/28/2016
NAME OF PROVIDER OR SUPPLIER **TROPICAL GARDEN VILLAS INC. (H**	STREET ADDRESS, CITY, STATE, ZIP CODE **432 SOUTH 'F' STREET** **LAKE WORTH, FL 33460**	

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

On 7/15/16 at 12:40 PM, and interview was conducted with Resident #6, and he was asked if he could verify that he gets his at 8 PM each night. The resident could not confirm what medications were being provided during the 8 PM medication pass.

On at 12:30 PM, the Administrator acknowledged the missing intials on the MOR for Resident #6.

Class III

0162 Records - Resident

Based on resident record review and staff interview, the facility failed to ensure resident records were complete and available for review, for 6 out of 12 sampled residents (Residents #2, #3, #4, #5, #7, #9).

The findings include:

On / , all 12 Resident Records were reviewed for the residents currently residing at Tropical Garden Villas (Home). The following residents were found with missing and/or inaccurate documentation within their file (Residents #2, #3, #4, #5, #7, #9).

1) Resident #2 :
a) Resident ' s most current AHCA Form 1823 was missing pages 1 of the Assessment Form, which contains Resident ' s height and weight, diagnoses, and any physical or sensory limitations, or behavioral status, Nursing/treatment/ requirements, and special precautions.

2) Resident #3:
a) Page 5, Section 3 (Services Offered or Arranged by the Facility for the Resident) of AHCA Form 1823 was not completed.
b) CLSP/ was not updated annually. The last Plan and Agreement was completed on . Case Manager ' s signature was not dated.
c) The latest , , ( ) Form was completed on . This Form was not updated annually.

3) Resident #4 :
a) Pages 3 and 4 were missing from this resident's AHCA Form 1823 (Page 3 includes information

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910385	**07/28/2016**
NAME OF PROVIDER OR SUPPLIER **TROPICAL GARDEN VILLAS INC. (H**	STREET ADDRESS, CITY, STATE, ZIP CODE **432 SOUTH 'F' STREET LAKE WORTH, FL 33460**	

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

regarding Self-Care and General Oversight Assessments, and Page 4 includes current medications, whether resident needs medication assist or administration, and the health care provider ' s signature, credentials, and date of assessment).
b) On page 1 of the Resident ' s Community Living Support Plan and Agreement (CLSP/), the following pertinent information is missing:
1) Name of ALF Administrator, the name of the Resident ' s Power of Attorney/Legal Guardian and contact information, the name of the Resident ' s Primary Care Physician and contact information, and the name of the Resident ' s Psychiatrist.
2) It also fails to provide Mental Health Program Office Contact number. The CLSP/ does not indicate the additional assessment conducted to determine the appropriateness for placement (i.e. Alternate Care Certification for , , ( ) Form, Discharge statement or form from a State Mental Hospital, A signed statement by approved Mental Health Provider that resident has been assessed and found appropriate for residency in an ALF).
c) Page 2 of the CLSP does not indicate the responsibilities of the facility in assisting the resident with attending appointments and activities, or the additional services and activities currently available to the resident.
c) Page 3 of the CLSP/ does not contain signature and date of ALF Administrator or Designee, or date of signature for Case Manager.
d) Resident file did not contain copy of Form for this resident and indication of SSI or SSDI (Social Security Income or Social Security Income).
The Administrator verbally affirmed on / at approximately 10:45 AM this resident did receive and was a Limited Mental Health resident (LMH).

4) Resident #5:
a) The Form indicates this resident ' s mental health provider assessed the resident as appropriate for ALF based on CLSP, but there is no CLSP/ in resident's file.
No Case Manager indicated on Form.

5) Resident #7:
a) Resident receives according to Administrator, but there is no Form on file.

6) Resident #9:
a) During an interview with the Adminsitrator on at 11:30 AM, he confirmed this Resident is Medicaid Waiver Assist and LMH resident; however, there is no Form in this resident's file.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910385	**07/28/2016**
NAME OF PROVIDER OR SUPPLIER **TROPICAL GARDEN VILLAS INC. (H**	STREET ADDRESS, CITY, STATE, ZIP CODE **432 SOUTH 'F' STREET LAKE WORTH, FL 33460**	

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

7) Residnet #11:
a) Resident is Medicaid Waiver Assist and recieves , per Administrator interview on 7/15/16 at 11:30 AM; however, this Resident does not have an Form in his record.

8) Resident #12:
a) Facility did not sign and date CLSP/ for this resident. CLSP is dated / and has not been updated annually.
b) This resident recieves , per Administrator interview on at 11:30 AM; however, this Resident does not have an Form in his record.

On / at 11:30 AM, the Administrator and Manager acknowledged the missing documentation from these residents' records.

Class III

L240 LMH - Licensing

Based on record review and staff interview, the facility failed to obtain a Limited Mental Health License for 4 out of 4 Limited Health Residents being served by the facility (Residents #3, #4, #9 and #12).

The findings include:

On / beginning at 10:30 AM, during resident record reviews, each resident record with mental diagnosis on AHCA Form 1823 was reviewed with the Administrator. The Administrator was asked if each resident 1) had a mental health diagnosis, 2) had a case manager, 3) had a Community Living Support Plan and Agreement, and 4) received ( ) and Social Security Income or Social Security Income . The Adminstrator answered "Yes" to 4 of the residents currently residing at the facility (Residents #3, #4, #9, and #12).

During interview with the Administrator on / at 12:50 PM, he acknowledged these 4 residents identified above met the criteria for being a Limited Mental Health (LMH) resident. The Administrator also acknowledged he had not obtained a LMH license for this facility.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Tropical Garden Villas Inc. (H)
432 South 'F' Street
Lake Worth, FL 33460

RE: CCR #2016004594

Dear Administrator:

This letter reports the findings of a State Licensure Survey that was conducted on , 2016 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 , 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 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com