STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911636	**02/02/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT CYPRESS VILLAGE, THE	**4600 MIDDLETON PARK CIRCLE, E. JACKSONVILLE, FL 32224**

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

0000 Initial Comments

A complaint investigation (CCR #2016013686) was conducted at Inn at Cypress Village Assisted Living Facility, (License #7720) on . Inn at Cypress Village Assisted Living Facility had deficiencies at the time of the investigation.

0025 Resident Care - Supervision

Based an observations, record reviews, and staff interviews, the facility failed to provide care and services appropriate to meet the needs of the 58 residents who were currently residing in the facility on the 6th and 7th floor, by not following policies and procedures related to resident supervision.

The findings include:

On at 10:37 AM the call light in the Resident # 6 was activated by this surveyor. At 10:42 AM Employee B was observed entering the Resident #6, but did not reset the resident call light.

An interview on at 10:45 AM with Employee B, confirmed she did not reset the call light for Resident # 6 because she was not aware the call light was activated. She was asked how she would be notified if a call light had been activated for a resident, and she replied "We carry beepers that tell us who needs assistance". The employee then confirmed she did not have a beeper.

An interview was conducted on at 10:55 AM with Resident #4 who confirmed it takes the facility staff a long time to respond when she calls for assistance. The resident stated she had a few weeks ago and it took the staff 45 minutes to come and help her. She said " I live with my husband but he's not able to get me off the floor so I propped myself on the dresser and had to wait."

In an interview on at 11: 00 AM with Resident # 5, he stated when he presses the pendant to call for assistance, it takes the staff a long time to answer. He stated "It takes around 30-40 minutes to get help sometimes, so I don't push it."

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An interview on at 11:25 AM with Employee E, a Caregiver, confirmed if a resident needs assistance they have a pull cord in their and wear a pendant which they use to call for assistance. He stated when the resident calls for assistance it goes to the computer at the nurses station and we get it on our beepers we carry. She stated " The pendants are not very dependable though. They will go off sometimes when a resident doesn't push it and will not go off when they do. We even have to bring them down closer to the nurses station to reset them sometimes."

On at 11:27 AM the call light in the Resident # 9 was activated by this surveyor.

Employee F, a caregiver, was observed waling b the was interviewed at 11:31 AM she was asked it she knew Resident #9's call light was activated. The employee confirmed she did not have a beeper and was unaware the resident needed assistance.

An interview on at 11:34 AM with Employee D, confirmed he had a beeper and saw a call light was activated for Resident # 9 but the beeper listed a resident's name who doesn't live at the facility. He stated " I knew the resident didn't live here anymore so I didn't notify the other staff members." The employee confirmed the call light for Resident #9 had been activated for almost 10 minutes.

A review was conducted of the call system computer on at 11:43 AM along with Employee E. The computer was located on the 7th floor nurses station. Multiple alerts were observed on the screen from residents who needed assistance. Resident #9 information was seen listed on the screen with the right but the name of the resident is listed as a resident who is no longer living at the facility. Employee E, confirmed, the system is not accurate and there were residents listed on the screen that need assistance but were no longer living here.

She continued to say that Residents who lived in at the end of the hallway, which is further from the nurses's tation, have less reliable pendants.

An interview with the Administrator on at 12:25 PM confirmed the staff were expected to sign out walkie talkies and a beeper when they come in for every shift. The Administrator reviewed the beeper sign out log for today and confirmed that only 1 of the 4 staff members had a beeper for today. The Administrator was notified multiple residents on the call light system are labeled with the wrong

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name and staff's lack of follow up as a result of the inaccuracy of identification of the resident.

An interview was conducted on at 1:55 PM with Resident #8. He and his wife had both recently, and he stated that he had to wait for 30-45 minutes before the staff arrived to assist them. This surveyor then activated the call light in the resident's .

On at 12:07 Employee D, walked by the Resident #8 and did not go into the resident apartment to offer assistance. Employee D, was asked if he was carrying a beeper and confirmed he was. Upon review of the employee's beeper Resident #8 call was not listed as needing assistance.

In an interview with Resident # 7 on at 2:15 PM, he stated he has to wait a long time to get assistance. He said " It depends on the day, sometimes it's 5 minutes sometimes it's 35. This system is terrible."

An interview with the Administrator on at 2:25 PM confirmed the call light system is not working properly and she has called engineering to look at the systems and make repairs. She stated, "Admissions is responsible for entering the right information on a resident when they get a pendant upon moving in, and this is not being done correctly."

A review of the call light system log from until the current date was conducted along with the Administrator. The log revealed residents have waited for 30 minutes, and at times as long as 1 1/2 hours for assistance from staff . The Administrator confirmed the call lights are not being answered in a timely manner. (photographic evidence obtained)

A review was conducted of the facility Policy and Procedure for Resident Call System and Door alarm response dated . It read "Responding to a resident call system alerts - staff should respond within a timely manner. If he can not they should request assistance from another associate. The Maintenance director is responsible to make sure the call station buttons, pull or intercoms should be routinely checked to determine whether they are functioning properly." (photographic evidence obtained)

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An interview with the Administrator on at 2:38 PM confirmed maintenance has not been performing checks on the call light / pendant system.

CLASS III

0162 Records - Resident

Based on record review, and staff interviews, the facility failed to have documentation of the appointment of a health care surrogate, health care proxy, and power of attorney for Resident #1 out of 3 resident records sampled.

The findings include:

A record review for Resident #1 revealed the demographic sheet for the resident listed both her son and daughter as Power of Attorney and at the responsible party.

A review of the facility nurses notes dated revealed Resident #1 sustained a and the daughter was notified.

A review of the facility nurses notes dated revealed Resident #1 had a and the facility called and left a message with her daughter.

A review of the facility nurses notes dated revealed Resident #1 was in severe pain and the facility called and left a message for the daughter.

An interview with the Health and Wellness Director (HWD) on at 1:35 PM confirmed the POA for Resident #1 was her son. The HWD reviewed Resident #1's demographic sheet and confirmed both the son and daughter were listed as Power of Attorney and responsible partner, but it should have only listed the son. The HWD confirmed the demographics sheet was not accurate and stated "I don't know why it list the daughter but the son is definitely her Power of Attorney and he should have been called".

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