| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11964707 | 02/10/2017 |
| NAME OF PROVIDER OR SUPPLIER<br>**INDIGO PALMS** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**570 NATIONAL HEALTHCARE BLVD**<br>**DAYTONA BEACH, FL 32114** | |

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

**0000 Initial Comments**

On a biennial relicensure survey, in conjunction with a complaint survey (CCR #2016013641) was conducted at Indigo Palms (License #9261). Deficient practice was identified during the surveys.

**0010 Admissions - Continued Residency**

Based on record review and staff interview, the facility failed to obtain a new Resident Health Assessment (AHCA form 1823) for 1 resident who had a decline in condition and began receiving hospice services (Resident #1) out of 3 sampled residents.

The findings include:

Record review for Resident #1 revealed he was admitted on . He had a resident health assessment (1823) dated which revealed a diagnosis of . He was independent with ambulation, toileting, eating , and transferring. He needed supervision for bathing.

Physician visit notes on revealed Resident #1 had severe and recurrent Accidents ( ) over the past 12 months. He was currently non-ambulatory and aphasic (unable to communicate). On , the hospice doctor had a face to face encounter with Resident #1. He wrote that the patient was referred to hospice services due to multiple , decreased oral intake, and non-verbal. He was dependent for all activities of daily living. (ADL).

Further review of the record revealed no new health assessment was obtained following the significant change in condition with referral to hospice. The was no longer accurate, and a new health assessment was required.

The Director of Nursing confirmed the resident's health assessment was no longer accurate in an interview on at 1:15 p.m..

Class III

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**0027 Resident Care - Arranaement for Health Care**

Based on resident record review and staff interview, the facility failed to assist with obtaining a appointment for 1 of 3 sampled residents reviewed for (Resident #1).

The findings include:

Record review revealed Resident #1 was admitted on . His hospital records (dated ) revealed he had , , , and with encounter for therapeutic drug level monitoring. Discharge orders were for a follow-up in 2 weeks for (anti- medication used to control ) , . Review of the physician's orders for Resident #1 revealed he was receiving (an anti- medication) 100 milligrams (mg) twice a day for . There was no evidence in the clinical record that this follow up appointment was made.

On at 0900 , the resident was sent to the local hospital for suspected activity on . He returned from the hospital the same day . His patient visit information revealed he was seen for , (an of the , system), reported ,and subtherapeutic level. Additional instructions were recommendations for and , (an anti- medication) levels to be rechecked in one week. There was no or , levels in the facility's clinical record for Resident #1.

The Director of Nursing confirmed there was no follow-up completed for Resident #1 in an interview on at 12:08 p.m.. She reviewed his record and could not find any lab follow-up for or , levels for Resident #1.

Class III

**0052 Medication - Assistance with Self-Admin**

Based on observation, resident record review and interview with staff, the facility failed to assist with the self-administration of medication in accordance with Section 429.256(3), F.S., by failing to adhere to the prescribed written instructions for 1 of 5 sampled residents' medication (Resident #15).

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The findings included:

An observation of Resident #15 was conducted at 12:40 pm on . Resident #15 entered the medication by Employee E, a Medication Technician. After reviewing the medication observation record (MOR) for Resident #15, Employee E retrieved a pharmacy-issued medication pack from the medication cart. She dispensed 1 tablet into a paper soufflé cup. Employee E handed the cup to Resident #15, who took his medication with a glass of water. Employee E noted her initials on the MOR to indicate she had assisted Resident #15 with the self-administration of this medication.

A review of the pharmacy label on the medication pack revealed Resident #15 had taken 1 (a medication used to treat high ) 25 milligram (mg) tablet. The label instructed to take 1 tablet every 8 hours. Review of the MOR revealed Resident #15 was scheduled to receive the at 7:00 am, 3:00 pm, and 11:00 pm. The 7:00 am dose had been signed as given, and the 3:00 pm dose had also been signed as given by Employee E (Photocopy obtained) during the 12:40 pm observation.

An interview was conducted with the Director of Nursing (DON) on at 2:39 pm. She reviewed the MOR and confirmed Resident #15's 3:00 pm dose of was received early, and out of the acceptable timeframe for the prescribed dose.

Class III

**0054 Medication - Records**

Based on resident record review and staff interview, the facility failed to maintain a daily Medication Observation Record (MOR) for 2 of 16 sampled residents (Residents #1 and #15).

The findings include:

1. Record review for Resident #1 revealed he was admitted on . He had a resident health assessment (AHCA form 1823) dated which noted a diagnosis of . He needed assistance with self-administration of medications. Review of the 2016 MOR revealed there were several days when his medications were not signed as received. There was no documentation that

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assistance with the self-administration of his medication was provided on , 23rd and 24th for (an anti- medication) 15 milligrams (mg), (an anti-convulsant medication used to control ) 100 mg, (also an anti- ) 500 mg, (used for high ) 75 mg, or (anti- ) 500 mg on the evening shift.

2. A review of Resident #15's MOR for , 2017 revealed he was scheduled to receive (used to treat high ) 25 mg every 8 hours at 7:00 am, 3:00 pm and 11:00 pm. The corresponding signature boxes for this medication, intended for signature after the medication was taken by the resident, were blank for the 7:00 am and the 3:00 pm doses on . There was no indication on the MOR why the resident did not receive his medication.

An interview was conducted with the Director of Nursing on at 1 p.m.. She reviewed the MORs for Residents #1 and #15, and confirmed the omissions.

Class III

**0093 Food Service - Dietary Standards**

Based on observations, facility record reviews, and interviews with staff, the facility failed to document menu substitutions before or when the lunch meal was served for 1 of 1 meals observed during the survey.

The findings included:

An observation of the lunch meal conducted at 12:00 pm on found residents were offered a choice of either beef stuffed cabbage rolls or chicken and vegetables over noodles. Menu accompaniments included cooked carrots, green beans, and rolls (photocopy obtained).

A review of the facility menu, signed by the Registered Dietician on , revealed the lunch meal for the day of observation called for either chicken Alfredo with pasta, or deluxe hamburger with baked beans with a baked sweet potato half, broccoli, and rolls.

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An interview was conducted with Employee F, a cook, on [redacted] at 3:12 pm. She stated she did not have enough food to prepare the menu item for the lunch meal, so she made an alternate meal. She stated she did not document the substituted meal, and did not know where substitutions were documented.

Class III

**0160 Records - Facility**

Based on a review of facility records, and interview with staff, the facility failed to maintain a complete admission and discharge log that included the identification of the facility or home address to which the resident relocated for 6 un-sampled and discharged residents who no longer resided in the facility.

The findings included:

A review of the admission and discharge log revealed there 6 discharged residents who did not have a discharge location documented under the "disposition" section of the log.

An interview was conducted with the Office Manager (OM) at 1:22 pm on [redacted]. She reviewed the log, and confirmed there was no discharge location noted for the 6 discharged residents.

Class III