STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966519	03/08/2017
NAME OF PROVIDER OR SUPPLIER **INDIGO PALMS AT MAITLAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **740 NORTH WYMORE ROAD** **MAITLAND, FL 32751**	

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

0000 - Initial Comments

A complaint investigation #2016014670 was conducted on . Indigo Palms at Maitland Assisted Living, (License# 10704) had deficiencies at the time of the visit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interview the facility failed to ensure proper supervision, and maintain a general awareness of the resident's whereabouts for 1 of 8 sampled residents (#14) for 2 days; and the facility failed to notify the physician and family/legal representative.

Findings:

Resident #14's record review revealed no documentation that resident #14 was not in the facility & admitted to the hospital after on . Additionally, there was no documentation that the healthcare provider and family/legal representative was notified.

On at 9:30 AM, an interview with the Resident Care Director who stated that resident #14 was on a leave of absence and had signed out to go to on (2 days before).

On at 9:35 AM, an interview with the Administrator who stated that the resident #14 is allowed to sign in/out of the facility anytime, it is the resident's right.

On at 2 PM, an interview with the Resident Care Director whom stated that resident #14's family came to visit on requesting where resident #14 was, but facility was not able to provide the family an answer.

On at 4 PM, an interview with the Resident Care Director stated that she found out by another family member that resident #14 had a scheduled procedure at the hospital after his on but resident #14 did not tell anyone.

On at 6 PM, an exit interview with the Administrator and Resident Care Director confirmed the facility was not aware of resident #14's whereabouts.

The resident left for and did not return. The facility did not attempt to check with the center in reference to the status of resident #14. There was no documentation that the resident's family or responsible party was notified when the resident did not return from .

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Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on resident interview and record review and interview the facility failed to ensure that all medications were refilled in a timely manner for 1 of 4 sampled residents (#12).

Findings:

During an observation on at 12:00 PM an empty bottle of 12% lotion. The empty bottle was observed in the seat storage of resident #12's walker. The prescription label was marked as being filled in 2016.

In an interview with resident #12 on at 12:00 PM, the resident stated she had been trying to get a refill for well over a month but none of the staff had ordered it yet.

A review of the record for resident #12 revealed a physician order dated for 12% Lotion; Refills x 11; Apply to legs daily, patient can apply by herself and keep in her .

In an interview with the Resident Care Director at 4:00 PM on , she said the lotion had not been refilled since 2016. The Resident Care Director put an order to refill in after we spoke and provided verification the order was faxed to the pharmacy. She offered no explanation as to why prescription was not refilled sooner.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on personnel record review and interview, the facility failed to have evidence showing 3 of 9 sampled staff (D, E and F) had received the required in-service training within 30 days of employment.

Findings:

1. Personnel record review revealed Staff D had not received a minimum of 1 hour in-service training that covers the following subjects: Elopement response, Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. Staff D was hired on in the role of LPN.

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2. Personnel record review revealed Staff E had not received a minimum of 1 hour in-service training that covers the following subjects: Elopement response and facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. Staff E was hired on in the role of LPN, night supervisor.

3. Personnel record review revealed Staff F had not received a minimum of 1 hour in-service training that covers the following subjects: Elopement response, Reporting major incidents, and Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. Staff F was hired on in the role of LPN, evening supervisor.

In an interview with the Resident Care Director on at 4:30 PM, she confirmed that certificates for these trainings were not in the personnel records and she did not have proof that Staff D, E or F received the above mentioned training.

Class III

0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on personnel record review and interview the facility failed to have evidence showing that 1 of 9 sampled staff (G) who provided direct care to residents had received and First Aid training.

Findings:

Personnel record review revealed Staff G did not have documented evidence of receiving training in First Aid and . Staff G was hired on as a CNA on the 10pm-6am shift. The staff schedule did not show that nurses were on duty at all times on the night shift.

In an interview with the Resident Care Director on at 4:30 PM, she confirmed that staff G did not have current First Aid or training. She also confirmed that the staff schedule reflected they do not have a nurse on the night shift at all times.

Class III

0086 - Training - ADRD - 58A-5.0191(9) FAC

Based on personnel record review and interview, the facility failed to ensure that 2 of 9 sampled staff (D & E) who provide direct care to residents with 's and Related (ADRD) had the 4 hours of initial training within 3 months of hire.

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Findings:

Personnel record reviews for Staff D, hired on and Staff E, hired on revealed no documentation of the initial 4 hours initial training for ADRD within 3 months of employment.

In an interview with the Resident Care Director on at 4:30 PM, she confirmed that she did not have documentation that Staff D or E had the required 's training.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on personnel record review and interview the facility failed to ensure that 6 of 9 sampled staff (D, E, F, G, H & I) received 1 hour of training regarding ( ) within 30 days of hiring.

Findings:

Review of the personnel records for the following staff members revealed there was no documentation of the 1 hour required training in the facility's policies and procedures regarding within 30 days of employment.
:

1. Staff D- Hired
2. Staff E- Hired
3. Staff F-Hired
4. Staff G-Hired
5. Staff H-Hired
6. Staff I- Hired

In an interview with the Resident Care Director on at 4:30 PM, she confirmed that she did not have certificates showing that any of the above 6 staff members had received the training.

Class III