STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968596	**03/24/2017**
NAME OF PROVIDER OR SUPPLIER **REGAL PARK ASSISTED LIVING, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1708 NE 4TH STREET** **BOYNTON BEACH, FL 33435**	

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

0000 - Initial Comments

An unannounced complaint investigation (CCR 2017002960) was conducted at Regal Park Assisted Living (license 12470) in Boynton Beach, Florida on . . . . - . . . . . . Deficient practice was found at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on observation, interview and record review the facility failed to properly complete the Resident Health Assessment (AHCA Form 1823), for 1 of 3 sampled residents,(Resident #2).

The findings include:

Record review of Resident #2 medical records indicated the resident was admitted on . Review of the current Resident Health Assessment Form dated on . . . . indicated the resident had a diagnosis of . The assessment indicated that Resident #2 was alert and able to self -administer her own . . and perform daily . . . . glucose monitoring testing. Further review of the form indicated the resident required assistance with self administration of medications.

During an interview with Resident #2 on at 11:30 AM, she stated that she does not administer her own . . . She stated that a Home Health nurse comes twice daily to check her . . . . glucose and administers as needed.

Review of the 2017 Medication Observation Record indicated that Resident #2 glucose level was being monitored twice daily by the Home Health Nurse and Novalog . . sliding scale was being administered as per physician orders.

During an interview with the Wellness Coordinator on at approximately 1:30 PM, she was questioned about the resident's medication requirements and stated that Resident #2 required medication management. She stated the 1823 form was incorrect and should be update to reflect current practice for the resident.

Class III

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

Based on interviews and record review, the facility failed to provide care and services appropriate to meet the needs of the resident. This was evidenced by the failure to provide required oversight and

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documentation of observations after hospitalization, for 1 of 1 sampled residents (Resident #1).

The findings include:

Review of Resident #1's medical record indicated he had medical conditions including , , , , , and , . Review of the resident's current 1823 resident assessment form dated on indicated he was alert, oriented and independent for all activities of daily living. The assessment indicated the resident required assistance with self administration of his medications and daily oversight for wellbeing and whereabouts.

Review of Resident #1's medical record indicated on a hospitalization for complaint of chest pain. Review of the hospital discharge instructions dated on indicated the resident should follow up with the facility physician and also with the hospital department within one week.

Review of the provided hard copies of facility electronic clinical progress notes dating from to indicated no documentation of any resident observation on Wednesday for complaints of chest pain or any response made by the care staff. Further review of the clinical notes indicated no documentation of any observations of Resident #1's condition when he returned to the facility on Thursday, or for days after his return.

During an interview with the Wellness Coordinator on at 11:45 AM regarding the lack of documentation of oversight after hospitalization for Resident #1, she stated that she routinely documented the resident complaints and transfers to the hospital in the electronic record. She stated that she would expect the staff to document observations of the resident when returning from the hospital. She reviewed the written documentation that she had provided the surveyor and confirmed no written observations were made. She stated that she was on vacation during the time frame being discussed. She stated that she would expect the care staff to document in her absence.

During an additional interview with the Wellness Coordinator on at 12:30 PM, she provided a written copy of an "internal only" communication log sheet dated which indicated " Resident #1 complained of a sharp pain in his chest" and " wanted to go to the hospital". The log indicated the resident was transferred 911 to the hospital for evaluation. Further review of the log dated on indicated Resident #1 returned back to the facility. The Wellness Coordinator stated that she could not locate any documentation of the resident's condition when he returned or observations made by the care staff. She provided a copy of an "additional note" that she had located, which she stated was completed by the front desk receptionist for the facility nurse, dated . The note indicated Resident #1 returned back to the facility on at 7:10 PM, with no medical findings or new orders and the

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resident would followed up with physician on . . . . . if needed. The Wellness Coordinator stated that she could not determine if Resident #1 was seen by the physician or if he had gone to a followup appointment as recommended on the hospital discharge.

In an interview with the facility nurse on at 12:45 PM, she stated that she worked day shift, 8 AM to 5:30 PM, Monday thru Friday. She stated that she was unfamiliar with Resident #1 's medical history and could not recall any specific details about the residents complaint of chest pain, or his return to the facility on . . . . . .

During an interview with the Home Health Agency Manager on . . . . . at 2:35 PM, she stated that Resident #1 had been receiving weekly visits by the nurse for , , conditions. She stated that the nurse had visited the resident on and then again on . . . . . . The manager stated that she had not received any physician orders for any evaluation regarding the resident's hospitalization on . . . . . .

During an interview with Resident #1's physician on . . . . at 2:52 PM, he stated that he had reviewed his office notes and determined that he had not evaluated the resident on since the resident was out of the facility at an appointment on that day. He stated the next recorded visit for Resident #1 was on .

Further review of Resident #1's medical record indicated no documentation by the facility nurse or any other facility staff member regarding any observations made of the resident upon his return from the hospital on . The medical record further indicated the next entered care note was dated on . . . . . .

Class III