STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965093	**04/21/2017**
NAME OF PROVIDER OR SUPPLIER **CHATSWORTH AT PGA NATIONAL**	STREET ADDRESS, CITY, STATE, ZIP CODE **347 HIATT DRIVE** **PALM BEACH GARDENS, FL 33418**	

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

0000 - Initial Comments

An unannounced abbreviated relicensure survey with ECC was conducted on through at Chatsworth at PGA National, License #9586. The facility had deficiencies at the time of the visit.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation and interview it was determined the facility failed to ensure the telephone number for lodging complaints against a facility or facility staff was posted in a common area accessible to all residents in the Memory Care Unit and in the Assisted Living Unit of the facility. In addition, based on observation, interview, and record review it was determined the facility failed to provide access to adequate and appropriate health care consistent with established and recognized standards within the community, specifically related to the timeliness of medications for 3 of 6 sampled residents (Resident #2, Resident #3, and Resident #4).

The Findings included:

1) During tour of the facility conducted with Staff H, on beginning at approximately 10:00 AM, she was provided the opportunity to locate all required telephone numbers for lodging complaints against a facility or staff member in the Assisting Living Unit of the facility. Staff H was not able to locate the AHCA complaint hotline telephone number or the telephone number for , Rights Florida. Staff H was not able to locate the AHCA complaint hotline telephone number; , Rights Florida telephone number; the Long-Term Care Ombudsman's telephone number; or the The Florida Hotline telephone number in the Memory Care Unit. The DON subsequently acknowledged that these numbers were not posted as required.

2) During observation of medications conducted in the Memory Care Unit with Staff A, on beginning at approximately 8:45 AM through 10:45 AM, Staff A provided medications to Resident #2, Resident #3, and Resident #4. She also assisted with the breakfast meal during medication observation (between Resident #2 and Resident #3). During interview with Staff A (unlicensed staff), conducted on beginning at approximately 10:40 AM, she was asked how many residents does she still need to provide assistance with medications. She replied, "Two". During interview conducted with Staff G (Registered Nurse), on beginning at approximately 10:45 AM, she was asked how may residents does she still have remaining to conduct medication administration. She replied, "One more in Memory Care and a couple in Assisted Living". She was asked if medications usually run this late. She acknowledged that they do.

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Review of Resident #4's MOR (Medication Observation Record) for , 2017, indicated the medications that were provided at 10:25 AM on , were scheduled for 8:00 AM.

During subsequent interview conducted with the DON (Director of Nursing), on beginning at approximately 11:00 AM, she was asked what the expectation of the timeliness of the provision of medications and provision of assistance with medications is for this facility. She stated 1 hour before the scheduled time through 1 hour after the scheduled time is the community standard. Review of the facility's policy entitled 6.2 Medication Administration, Assistance or Observation Times, indicated "The community should commence medication administration, assistance or observation within sixty (60) minutes before the designated times of administration and sixty (60) minutes after the designated times of administration.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observations, interviews, and record reviews, it was determined the facility failed to ensure all medications, that require central storage, were maintained in a secured/locked manner at all times for 3 of 6 sampled residents (Resident #2, Resident #4, and Resident #9). Based on observation and interview it was determined the facility failed to dispose of medications in an safe manner, for 2 of 6 sampled residents (Resident #2 and Resident #4).

The Findings included:

1) During observation of Staff A providing assistance with the self administration of medication for Resident #2, on beginning at approximately 8:40 AM, Staff A gathered all medications and supplies and entered Resident #2's . She left the medication cart next to the dining area (with approximately 6 residents) unlocked in this Memory Care Unit. She was reminded by this surveyor not to leave the medication cart unlocked and unattended. She acknowledged that she had left the medication cart unlocked and unattended.

2) During observation of Staff A providing assistance with the self administration of medication for Resident #2 on the Memory Care Unit, on beginning at approximately 8:40 AM, Staff A dropped 3 pills on the floor (1mg; 20mg; and , 200mg). Staff A gathered these medications and placed them back in a small plastic up and set them down on this resident's dresser and proceeded to provide assistance with the self administration of medication for this resident. Upon completion of providing assistance with the self administration of medications for Resident #2, Staff A left her left the medications that had on the floor on this resident's

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dresser. After walking back to the medication cart and putting away supplies, Staff A was asked (by this surveyor) if she had forgotten something. She could not identify that she had forgotten medications in Resident #2's she was reminded (by this surveyor).

3) During observation of Staff A providing assistance with the self administration of medication for Resident #4 on the Memory Care Unit, on beginning at approximately 10:25 AM through 10:40 AM, she left the following medications unattended in Resident #4's (within the reach of this resident) to obtain cups of water on two separate occasions: ; 5mg; SR 150mg; 600 with D 400u; 100mg; Mag 40mg; Poly-Iron 150mg; 0.025mg; 10mg; and Polyeth bottle of powder.

4) On at 9:37 AM, Staff F was observed assisting Resident #9 with self-administered medications. Staff F sanitized her hands, removed 6 of Resident #9's medication cards from the locked medication cart and compared the label to the medication observation record (MOR). Staff F took the 6 medication cards into Resident #9's placed them on the over-the-bed table which was located in front of the chair where Resident #9 was seated. Staff F, then, left the resident's get a container of applesauce that was left on the medication cart in the hallway outside of Resident #9's . The 6 medication cards were left unattended, within reach of the resident, and out of the Staff F's sight.

Upon return, Staff F informed Resident #9 of the medications being given, removed the medication from the labeled medication cards, and placed them into a small, plastic cup. When all medications were in the small cup, she then dumped the pills into the container of applesauce, stirred them up, and handed the applesauce and a spoon to the resident. The resident fed herself all of the mixture while being observed by Staff F. Staff F removed the medications cards after observing the resident take all of the pills with the applesauce, she returned them to the locked medication cart, and initialed the MOR.

5) During observation of Staff A providing assistance with the self administration of medication for Resident #2 on the Memory Care Unit, on beginning at approximately 8:40 AM, Staff A dropped 3 pills on the floor (1mg; 20mg; and 200mg). Staff A gathered these medications and placed them back in a small plastic up and set them down on this resident's dresser and proceeded to provide assistance with the self administration of medication for this resident. Upon completion of providing assistance with the self administration of medications for Resident #2, Staff A left her left the medications that had on the floor on this resident's dresser. After walking back to the medication cart and putting away supplies, Staff A was asked (by this surveyor) if she had forgotten something. She could not identify that she had forgotten medications in Resident #2's she was reminded (by this surveyor). Staff A then proceeded to place these

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unused medications (that had on the floor) in the open trash receptacle on the side of the medication cart in the Memory Care Unit. She was asked if that is how she routinely disposes of medications, she then proceeded to gather these medications out of the trash receptacle and place them in the sharps container on the medication cart.

6) During observation of Staff A providing assistance with the self administration of medication for Resident #3 on the Memory Care Unit, on beginning at approximately 10:10 AM, Staff A had placed this resident's Allopurinal 100mg into a small plastic up and offered it to this resident. Resident #3 adamantly refused to take medication. Staff A then proceeded to place this small plastic cup with the Allopurinal 100mg in the top drawer of the medication cart instead of properly disposing of this medication.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on interview and record review, it was determined the facility failed to obtain within 30 days of employment, a written statement from a health care provided documenting that the individual does not have any signs or symptoms of communicable for 4 of 4 sampled staff (Staff A, Staff B, Staff C, and Staff D). In addition, based on interview and record review it was determined the facility failed to obtain evidence of a negative examination on an annual basis for 3 of 4 sampled staff (Staff A, Staff B, and Staff C).

The Findings included:

1) During interview and personnel record conducted with the HR (Human Resources) Director and the DON (Director of Nursing), on beginning at approximately 1:00 PM; they confirmed that the following staff did not have any written statement from a health care provided documenting that the individual does not have any signs or symptoms of communicable :

a) Staff A with a date of hire noted as
b) Staff B with a date of hire noted as
c) Staff C with a date of hire noted as
d) Staff D with a date of hire notes as

The HR Director explained that this facility utilizes a questionnaire that the employee completes and that the medical director signs and dates. The HR Director and the DON acknowledged that this form does not provide a written statement from a health care provider documenting that the staff member does not

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have any signs or symptoms of communicable .

2) During interview and personnel record conducted with the HR (Human Resources) Director and the DON (Director of Nursing), on beginning at approximately 1:00 PM, they confirmed that the following staff did not have any evidence of a negative examination on an annual basis:

a) Staff A with a date of hire noted as : no documentation for 2015 ad 2016
b) Staff B with a date of hire noted as : no documentation for 2015 and 2016
c) Staff C with a date of hire noted as : no documentation for 2017

The HR Director explained that this facility utilizes a questionnaire that the employee completes and that the medical director signs and dates. The HR Director and the DON acknowledged that this form does not provide evidence of a negative examination on an annual basis.

Class III

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

Based on interview and record review, it was determined the facility failed to ensure staff that provide direct care to residents received training in the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation and training in the facility's resident elopement response policies and procedures within 30 days of employment, for 1 of 3 samples direct care staff (Staff C).

The Findings included:

During interview and personnel record review conducted with the HR (Human Resources) Director and the DON (Director of Nursing), on at approximately 2:00 AM, they were provided the opportunity to locate Emergency Procedures training and the Resident elopement response training, specific to the facility's policies and procedures, within 30 days of employment for Staff C (direct care staff with a date of hire noted as). They were not able to locate this required documentation at the time of this review.

Class III

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

Based on interview and record review it was determined the facility failed to ensure that each direct care staff received at least 1 hour of training in the facility's policies and procedures regarding 's within

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30 days after employment for 1 of 3 sampled staff (Staff C).

The Findings included:

During interview and personnel record review conducted with the HR (Human Resources) Director and the DON (Director of Nursing), on at approximately 2:00 AM, they were provided the opportunity to locate training on the facility's policies and procedures within 30 days of employment for Staff C (direct care staff with a date of hire noted as). They were not able to locate this required documentation at the time of this review.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and interview it was determined the facility failed to conspicuously post or make easily available to the residents the menu on the Memory Care Unit.

The Findings included:

During observation and interview conducted with the DON (Director of Nursing), on beginning at approximately 10:55 AM, she was asked where the menu is posted in the Memory Care Unit. She was provided the opportunity to look for this menu and was not able to find it. She asked the Registered Nurse where the menu is located. The Registered Nursing stated she did not know. The menu was not located at the time of this observation and interview with the DON.

Class III