STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965386	04/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH	2400 SOUTH CONGRESS AVENUE BOYNTON BEACH, FL 33426

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

0000 - Initial Comments

An unannounced CHOW (Change of Ownership) survey was conducted on - at Boynton Beach, License #9745. 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 provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S., specifically related to the facility's failure to provide a readily accessible telephone on each floor of the building where residents reside that is located in close proximity to required posting of the advocacy numbers for lodging complaints against a facility or facility staff in 4 of 4 buildings.

The Findings included:

An observational tour of building 4 was conducted with the ED (Executive Director), beginning at approximately 10:10 AM. She was asked if each resident has their own phone in their . She stated that they do not and this is not something that the facility provides in their . She was asked how residents without their own telephone have unrestricted access to a telephone where they can make a private call. She stated there is a wall mounted phone in the upstairs conference . Upon observation, this phone was mounted at a height of approximately 4.5 feet. This is not accessible for residents in wheelchairs. The ED stated residents could use a staff office phone. She was asked if a resident would have access to staff phones during the staff's off hours. She acknowledge that they would not. The advocacy numbers for lodging complaints is posted on the first floor in this building and there was no phone located near this mandatory posting and this was acknowledged by the ED. She also acknowledged that buildings 2 and 3 are set up in a similar manner to building 4, specifically related to the availability of a phone for the residents of these buildings.

Upon observation of the Memory Care Unit (building 1; which is one floor only) and interview with the ED, on beginning at approximately 10:25 AM, she was asked where a readily accessible phone is located on this unit for the residents that don't have a telephone where a resident can make a private call. She stated one is not available unless it is in a staff office. She stated they have never been cited for this before and why was this being looked at that now. It was explained to her that this is not a new regulation.

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on observation, interview and record review, it was determined the facility failed to ensure that each resident's OTC (Over The Counter) products, including those prescribed by a health care provider, was labeled with the resident's name and the manufacturer's label with directions for use, or the health care provider's directions for use for 1 of 9 residents observed for medication (Resident #9).

The Findings include:

During medication observation and interview conducted with Staff I (an unlicensed staff member), she provided assistance with Resident #9's medications, on beginning at approximately 9:15 AM. She provided the following medications to this resident which he consumed with applesauce (by his own choice):

a) with daily
b) Con 500mg x 2 tablets daily
c) 81mg daily
d) 100mg daily
e) 5mg (1/2 tablet) daily
f) NA 40mg twice daily
g) Meclizone 25mg three time daily

Staff I was asked why the 2017 MOR (Medication Observation Record) noted 625mg take 2 tablets by mouth once daily and the bottle of this OTC (Over The Counter) item indicated 500mg per tablet. Staff I could not provide any explanation. Staff I was also asked how she was sure this bottle of OTC belonged to Resident #9 as it was not label with his name or with the dosage to be provided to Resident #9. Staff I stated this bottle was with his other medications. She acknowledged the bottle was not labeled with Resident #9's name or dosing instructions for this resident at the time of this observation and interview.

During subsequent interview and record review conducted with Staff H (LPN - Licensed Practical Nurse), on beginning at approximately 1:50 PM; she provided a copy of Resident #9's medication orders (page 4 of 1823 form), dated . This document noted 625mg (2 tabs) daily by mouth. She acknowledged this was not the same dosage (500mg) which is on the label of the OTC bottle for Resident #9. She also acknowledged that the OTC bottle did not have instructions for dosage for the and that there was no label present on this bottle.

Class III

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